**Section 1915(b) Waiver**
**Proposal For**
**MCO, PIHP, PAHP, PCCM Programs**
**And**
**FFS Selective Contracting Programs**

MMA amendment version

**Table of Contents**

**Proposal for a Section 1915(b) Waiver**
**MCO, PIHP, PAHP, and/or PCCM Program**

**Facesheet**

*Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.*

The **State of Montana** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is **Passport to Health** and the **Nurse First Program.**

**Type of request**. This is a:

___ initial request for new waiver. All sections are filled.

___ amendment request for existing waiver, which modifies Section/Part ____

__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

__ Document is replaced in full, with changes highlighted

X renewal request

X This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

__ The State has used this waiver format for its previous waiver period.

Sections C and D are filled out.

Section A is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

**Effective Dates:** This waiver/renewal/amendment is requested for a period of two years; effective April 1, 2008 and ending March 31, 2010.

**State Contact:** The State contact person for this waiver is Mary Noel who can be reached by telephone at (406) 444-4146, or fax at (406)444-1861, or e-mail at manoel@mt.gov.

**Section A: Program Description**

**Part I: Program Overview**

**Tribal consultation**
*For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.*

During this renewal process the state of Montana contacted each Tribe to inform Tribes that the renewal to the waiver was taking place and how to make comments or suggestions during the process.

**Program History**
*For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).*

Medicaid serves 11 percent of Montana's population. Passport To Health Managed Care Program has been operating in Montana since January 1993. Passport was implemented on a county-by-county basis and all but two Montana counties are Passport counties. During normal operation about 70 percent of the Medicaid population is enrolled in Passport.

The Nurse First Disease Management Program was initiated in January of 2004. Nurse First is a PAHP for the management of select disease states. Nurse First includes a Nurse Advice and Identification Line (NAIL), telephonic disease management, and community based disease management by registered nurses.

The geographic and economic makeup of Montana is diverse. All 56 counties are designated rural or frontier, as defined by population density.[1] Montana is one of only three states with this designation. Based on 2000 Census Data, 902,195 people live in Montana, ranking it 44th in population. Only 22 percent of Montana's population lives in metropolitan areas, making Montana the nation's least urbanized state.[2]

With this sparse population comes a commitment to independence, community pride and a local approach to problem solving. Communities in both urban and rural areas have developed and implemented plans to address the health care needs in their own localities. Consumer coalitions, health care professionals, community leaders and interested persons have worked together to identify health care services and maintain a good referral system. Providers and their staff work hard at forging connections with other agencies and services of benefit to their patients.

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1 2002 Montana County Health Profiles, Demographics, Health Status Indicators, Health Resource Assessment, Montana Department of Public Health and Human Services.
2 Kaiser Family Foundation web site: www.statehealthfacts.org

While Montana ranks 44th in population in the nation, it is important to recognize that Native Americans make up 6 percent of our population and 26 percent of our Passport population; Hispanics comprise 2 percent; and 13 percent of our total population is age 65 and older. Montana has seven Indian reservations and a migrant farm population of approximately 10,400. Montana has the 13th highest percentage among states for people 65 years of age or older.[3]

There are more public road miles in Montana than Interstate miles in the entire United States. Seventy-seven percent of Montana's vehicle miles traveled takes place outside of our 14 urban areas.[4] Moreover, access to public transportation is limited to larger communities, such as Great Falls, Helena, Missoula and Billings. The rural nature of the state means long distances between providers and services.

Many services that other states consider basic, such as mass transportation, are not available in most areas of Montana. Both inter and intra city bus service is very limited and not a service in many areas of the state. Many Montanans rely on friends, neighbors, and relatives for their transportation needs. It is not unusual for providers in Montana to serve several counties in one week and some travel by air to offer health care services to the most remote areas of the state.

Team Care, a sub-program of Passport launched in 2004, is operated under the authority of 42 CFR 431.54(e), and is not held to the same requirements as Passport. Team Care clients have been identified as over-users of the Montana Medicaid system. Team Care's goal is to reduce the inappropriate use of resources, particularly focusing on reducing unnecessary emergency room and physician office utilization. Clients are identified for this program through three avenues: claims data mining, provider referral, or Drug Utilization and Review board (DUR) referral.

Team Care clients are enrolled in the Passport to Health program (even if they would otherwise be excluded from the program). Enrollment in Passport allows the State to use the Passport enrollment process and the Passport provider network. Team Care clients must also select one pharmacy from which all Medicaid paid pharmaceuticals are dispensed. The state encourages Team Care clients through outreach and education materials. If the client does not use the Nurse line they are still able to access Medicaid services. The client is not penalized for not using the service. It is the goal of Montana Medicaid to convince Team Care clients that it is to their benefit to use the service available to them. This purpose of this service is for the client to utilize a nurse for advice on what type and level of Medical care is needed. The program includes approximately 600 clients, the majority of whom are enrolled in Passport.

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**Deleted:** Team Care clients are encouraged to call the Nurse Advice and Identification Line prior to accessing Medicaid services, except in emergency situations.

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The following addresses the issues during the past waiver period in which the State issued a Request for Proposal for enrollment broker and provider relations services for the Passport to Health program. We describe issues discovered by the State that led to the halt of all enrollment activities and the dismissal of the enrollment broker.

3 US Census Bureau 2006 American Community Survey
4 Montana Department of Transportation web site: www.mdt.mt.gov

In December of 2005, the State of Montana issued a Request for Proposal for the Passport to Health Program for an enrollment broker to conduct both enrollment and provider relations functions for the Passport to Health program.

The new contract was awarded to Policy Studies Inc. (PSI). The contract period was March 1, 2006 through June 30,2009.

PSI was responsible for all enrollment broker functions as well as the provider relations for the Passport to Health program. PSI was not able to deliver items to the State required by the contract and reports provided by PSI contained inaccurate data. PSI failed to provide services ensured in their response to the State's RFP; thus PSI's request to be released from their contract. A list of contract problems follows.

- PSI did not enroll approximately 56,000 Passport clients into the program during a month. The result was that providers received no case management fees during this month since no clients were enrolled in the program. Anticipated Passport savings were lost during this month.

- PSI failed to provide accurate reports during the entirety of their contract. The State has been without accurate reports since the implementation of the contract with PSI. Our new contractor will be able to provide this function during the next waiver period and has already displayed the ability to generate accurate reports for the State.

- PSI had difficulty with their call center function. This resulted in poor customer service for Medicaid clients and providers.

- In December 2006, PSI requested to be released from the contract due to the inability to implement proper system changes without extreme costs not originally accounted for during the competitive bidding process. We agreed that PSI would be released from the contract once a new contractor was able to pick up the responsibilities of the program and continue the enrollment function.

- In January 2007, the State discovered PSI was inappropriately mailing client materials, resulting in excessive costs to the program. The State instructed PSI to stop enrolling clients into the Passport program; instead they should just maintain existing clients until a new contractor could take over.

- After contacting CMA and DPHHS legal staff concerning this issue, we determined the enrollment broker function could be incorporated into the State's MMIS contract. CMS reviewed this request, had several meetings with State staff, and approved the contract amendment to hire Affiliated Computer Services (ACS) as our next enrollment broker.

- PSI agreed to a settlement with the State for $800,000, a figure negotiated by estimates of damages to the State caused by PSI.

- ACS received an initial payment of $100,000 to cover costs of implementation for the enrollment broker contract.

- We agreed ACS would maintain only current Passport and Team Care clients until the system was properly implemented. The timeline was that ACS would begin to enroll the back log of clients in December 2007,

- Because PSI did not enroll new clients beginning February 2007 and ACS's system did not have the ability to enroll clients until December 2007, the program's numbers have dropped significantly to about 40 percent of the Medicaid population. ACS is implementing a phased approach to enrolling these clients and will increase enrollment to the proper percentage in 2008, which averaged 70 percent during past waiver periods. Due to the enrollment broker problems and their repayment of monies in R2, cost based for R1 were extrapolated into R2. Analysis was done to identify the number of clients who were eligible during R2 but not enrolled. This number was then used in conjunction with actual R2 costs to verify that the projected numbers used in cost effectiveness spreadsheets appropriately reflected the actual cost.

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**A. Statutory Authority**

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. **X 1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. **X** **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. **X** **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

___ MCO
___ PIHP
_X_ PAHP
___ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
___ FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a.___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

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c.X **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d. **Section 1902(a)(4) -** To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

## B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.___ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

___ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c._X_ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

_X_ The PAHP is paid on a risk basis.

___ The PAHP is paid on a non-risk basis.

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d.___ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ___ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
___ the same as stipulated in the state plan
___ is different than stipulated in the state plan (please describe)

f._X__ **Other:** (Please provide a brief narrative description of the model.)
Passport to Health is a PPCM that enrolls all willing providers and pays a per member per month case management fee to providers. Claims for medical services are paid to providers on a fee for service basis.

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

_X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience) **For PAHP**
___ **Open** cooperative procurement process (in which any qualifying contractor may participate)
___ **Sole source** procurement
X **Other** (please describe)

The current contract for the PCCM program is held by ACS. They were not awarded this contract through traditional means. PSI was awarded this contract in March of 2006 and requested to be released from the contract in December of 2006 due to the inability to perform the work required. ACS obtained the contract through an amendment to their current MMIS contract with the state of Montana. This process was approved by CMS and state legal staff.

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**Deleted:** **Please see program history in Section A, Part I for PCCM.¶**
**¶**

**C. Choice of MCOs, PIHPs, PAHPs, and PCCMs**

1. **Assurances.**

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

X__ The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP/PCCM. With our Nurse First PAHP program we mandate beneficiaries into one Disease Management Organization. However, the Nurse First programs are voluntary.

We believe that having one DMO provider allows us to provide consistent DM services to our entire population. Multiple DM providers may result in some of our areas possibly receiving more or better services than other areas. In addition, Montana's rural nature and small population would make it difficult to have more than one DM provider. We do not have a large enough population for that population to be split between multiple providers and still result in numbers large enough to be profitable for a DMO. In addition, more than one DMO would create an administrative and financial burden for the State.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
_X_ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X __ Other: (please describe) One provider for PAHP

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ( "rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

___ Beneficiaries will be limited to a single provider in their service

area (please define service area).

X Beneficiaries will be given a choice of providers in their service area.

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**D. Geographic Areas Served by the Waiver**

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

**Statewide** -- -- all counties, zip codes, or regions of the State have managed care (Please list in the table below)
McCone and Sanders counties are the only counties in Montana that have Medicaid providers who do not participate in the Passport To Health program. Clients who live in those counties are not eligible for the Passport To Health program.

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X **Less than Statewide**

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2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

| City/County/Region | Type of Program (PCCM, MCO, PIHP, or PAHP) | Name of Entity |
|---|---|---|
| *Beaverhead* | *PCCM and PAHP* | Passport/McKesson |
| *Big Horn* | *PCCM and PAHP* | Passport/McKesson |
| *Blaine* | *PCCM and PAHP* | Passport/McKesson |
| *Broadwater* | *PCCM and PAHP* | Passport/McKesson |
| *Carbon* | *PCCM and PAHP* | Passport/McKesson |
| *Carter* | *PCCM and PAHP* | Passport/McKesson |
| *Cascade* | *PCCM and PAHP* | Passport/McKesson |
| *Choteau* | *PCCM and PAHP* | Passport/McKesson |
| *Custer* | *PCCM and PAHP* | Passport/McKesson |
| *Daniels* | *PCCM and PAHP* | Passport/McKesson |
| *Dawson* | *PCCM and PAHP* | Passport/McKesson |
| *Deer Lodge* | *PCCM and PAHP* | Passport/McKesson |
| *Fallon* | *PCCM and PAHP* | Passport/McKesson |
| *Fergus* | *PCCM and PAHP* | Passport/McKesson |
| *Flathead* | *PCCM and PAHP* | Passport/McKesson |
| *Gallatin* | *PCCM and PAHP* | Passport/McKesson |
| *Garfield* | *PCCM and PAHP* | Passport/McKesson |
| *Glacier* | *PCCM and PAHP* | Passport/McKesson |
| *Golden Valley* | *PCCM and PAHP* | Passport/McKesson |
| *Granite* | *PCCM and PAHP* | Passport/McKesson |
| *Hill* | *PCCM and PAHP* | Passport/McKesson |
| *Jefferson* | *PCCM and PAHP* | Passport/McKesson |

| | | |
|---|---|---|
| *Judith Basin* | *PCCM and PAHP* | Passport/McKesson |
| *Lake* | *PCCM and PAHP* | Passport/McKesson |
| *Lewis & Clark* | *PCCM and PAHP* | Passport/McKesson |
| *Liberty* | *PCCM and PAHP* | Passport/McKesson |
| *Lincoln* | *PCCM and PAHP* | Passport/McKesson |
| *Madison* | *PCCM and PAHP* | Passport/McKesson |
| *McCone* | *PAHP* | McKesson |
| *Meagher* | *PCCM and PAHP* | Passport/McKesson |
| *Mineral* | *PCCM and PAHP* | Passport/McKesson |
| *Missoula* | *PCCM and PAHP* | Passport/McKesson |
| *Musselshell* | *PCCM and PAHP* | Passport/McKesson |
| *Park* | *PCCM and PAHP* | Passport/McKesson |
| *Petroleum* | *PCCM and PAHP* | Passport/McKesson |
| *Phillips* | *PCCM and PAHP* | Passport/McKesson |
| *Pondera* | *PCCM and PAHP* | Passport/McKesson |
| *Powder River* | *PCCM and PAHP* | Passport/McKesson |
| *Powell* | *PCCM and PAHP* | Passport/McKesson |
| *Prairie* | *PCCM and PAHP* | Passport/McKesson |
| *Ravalli* | *PCCM and PAHP* | Passport/McKesson |
| *Richland* | *PCCM and PAHP* | Passport/McKesson |
| *Roosevelt* | *PCCM and PAHP* | Passport/McKesson |
| *Rosebud* | *PCCM and PAHP* | Passport/McKesson |
| *Sanders* | *PAHP* | McKesson |
| *Sheridan* | *PCCM and PAHP* | Passport/McKesson |
| *Silver Bow* | *PCCM and PAHP* | Passport/McKesson |
| *Stillwater* | *PCCM and PAHP* | Passport/McKesson |
| *Sweet Grass* | *PCCM and PAHP* | Passport/McKesson |
| *Teton* | *PCCM and PAHP* | Passport/McKesson |
| *Toole* | *PCCM and PAHP* | Passport/McKesson |
| *Treasure* | *PCCM and PAHP* | Passport/McKesson |
| *Valley* | *PCCM and PAHP* | Passport/McKesson |
| *Wheatland* | *PCCM and PAHP* | Passport/McKesson |
| *Wibaux* | *PCCM and PAHP* | Passport/McKesson |
| *Yellowstone* | *PCCM and PAHP* | Passport/McKesson |

**E. Populations Included in Waiver**

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program: for PCCM

**_X__Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_X_ Mandatory enrollment
___ Voluntary enrollment

**_X_ Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_X_ Mandatory enrollment
___ Voluntary enrollment

**_X_ Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X_ Mandatory enrollment
___ Voluntary enrollment

**_X_ Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_X_ Mandatory enrollment
___ Voluntary enrollment

**_X_ Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

_X_ Mandatory enrollment
___ Voluntary enrollment

**___ Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

___ Mandatory enrollment
___ Voluntary enrollment

**___ TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

___ Mandatory enrollment
___ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

**_X_ Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

**___ Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

**_X__ Other Insurance--**Medicaid beneficiaries who have other health insurance. (possible exemption) These eligible clients have TPL that offers a PCP arrangement and insurance that covers a substantial portion of health care costs can apply for an exemption.

**_X_ Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

**___ Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

**_X_ Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program. (These clients are excluded from the Passport program but included in the Nurse First programs.)

_X__ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). These clients are excluded from the Passport program but included in the Nurse First programs.

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

_X_ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

_X_ **Other** (Please define):

_ __X__Medically needy clients with a spend down. These clients are included in the Nurse First programs but are excluded from Passport unless they are part of Team Care.

The system will have a separate program indicator for the Passport and Team Care programs. A medically needy client with a Team Care indicator will ensure the client's participation in the Team Care program. A client's medically needy status will be transferred to the contractor through the eligibility file received from TEAMs.

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__X__Clients living in an area without Medicaid managed care. These clients are included in the Nurse First programs but are excluded from Passport unless they are part of Team Care.

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_X___Clients in a Medicaid eligibility subgroup of subsidized Adoption

_X___Clients who cannot find a PCP who is willing to provide case management. These clients are included in the Nurse First programs but are excluded from Passport unless they are part of the subset of Passport called Team Care.

_X___Clients who reside in a county in which there are not enough primary care providers to serve the Medicaid population. These clients are included in the Nurse First programs but are excluded from Passport unless they are part of Team Care.

**F. Services**

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

**_X_** The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X_ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
_X_ Other (please explain): The State will pay for covered family planning services furnished by enrolled Medicaid providers.
___ Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
_X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that

gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Enrollees can select any PCP in the state including any of the FQHC's that are enrolled as Passport providers.

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___The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

X_The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

___This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

_X_The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Passport Clients can self-refer to any Montana Medicaid provider for the following services:

- Ambulance
- Anesthesiology
- Blood lead testing
- Christian science nurses & sanatoriums (EPSDT)
- Dental (except orthodontia & dental surgery)

- Dialysis
- Dialysis Attendant
- Drug/Alcohol outpatient treatment (EPSDT)
- Durable medical equipment
- Emergency Services
    - Emergency room screening
    - Emergency room services for emergent conditions
- Eye exams
- Eyeglasses
- Family planning
- Hearing aids
- Hearing exams
- Home & Community Based Waiver services
- Home care
- Home infusion therapy
- Hospice
- Hospital-nursing home care beds
- Immunizations
- Indian Health Service Clinic
- Lab
- Mental health services
    - Community mental health centers
    - Inpatient & outpatient with specific diagnosis
    - Inpatient hospital psych
    - Licensed professional counselors
    - Licensed social worker services
    - Other psych practitioner
- Nursing home and ICFIMR services
- Obstetrical services
- Ophthalmology services
- Optometry services
- Personal care attendant services
- Podiatry
- Pregnancy-related services
- Prescription drugs
- Prosthetic devices
- Residential treatment centers
- Skilled & intermediate nursing services in nursing facilities
    - ICF-MR services
    - Swing bed services
- STD (Sexually Transmitted Diseases)
    - Testing & treatment
    - Department designated sites
- Substance Abuse services

- Targeted Case Management
- Therapeutic foster care & youth group homes
- Transportation
- X-ray services

- **The Home and Community Based Waiver program has a separate deprivation code. A client will be indicated on the eligibility file as a Home and Community Based Waiver program member and will then be removed from Passport.**

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**Section A: Program Description**

**Part II: Access**

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

**A. Timely Access Standards**

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

*If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.*

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. _X_ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1._X_ PCPs (please describe):
Montana is a rural/frontier state, characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population
density, Montana does not use a single distance and/or travel time to gauge access. Instead, we determine through a variety of means like conversations with community members, whether Passport primary care providers are available in the normal service delivery area for each town or locale. In a frontier state such as Montana, this case-by-case approach is more meaningful to clients who are accustomed to living, and often choose to live, extended distances from services.

2._X_ Specialists (please describe): Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

3._X_ Ancillary providers (please describe your standard):
PASSPORT clients can, with a referral from his/her PCP, go to any Montana Medicaid provider

4._X_ Dental (please describe): Passport clients can go to any Montana Medicaid provider without a referral.

5._X_ Hospitals (please describe your standard):
PASSPORT clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

6_X_ Mental Health (please describe your standard):
Mental Health services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health providers.

7._X_ Pharmacies (please describe your standard):
Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider. Team Care clients are locked into one pharmacy. The pharmacy restriction can be lifted temporarily by Department staff or the enrollment broker if need be.

8._X_ Substance Abuse Treatment Providers (please describe your standard):

Substance Abuse Treatment services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health providers.

9._X_ Other providers (please describe):
Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

b. _X_ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1._X_ PCPs (please describe):
For both PCPs and other providers we have adopted the standards adopted by the state for HMOs.
This is as follows:
1. Emergency services must be available and accessible at all times.
2. Urgent care appointments must be available within 24 hours.
3. Appointments for non-urgent care with symptoms must be available within 10 calendar days.
4. Appointments for routine or preventive care must be available within 45 calendar days.

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7._X_ Urgent care (please describe):
Urgent care appointments must be available within 24 hours.

8.___ Other providers (please describe):

c. ___ **In-Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1.___ PCPs (please describe):
i.___ Capitated Program (please describe your standard):
Our capitated program is for DM only.

ii._X_ PCCM Program (please describe your standard):
We have not established standards for in-office wait times, however, we do monitor this for any problems through the Client Help Line and client surveys

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ Other providers

i.___ Capitated Program:
Our capitated program is for DM only.

ii. X__ PCCM Program (please describe your standard):
We have not established standards for in-office wait times, however, we do monitor this for any problems through the Client Help Line and client surveys.

d. ___ **Other Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

**B. Capacity Standards**

**1. <u>Assurances for MCO, PIHP, or PAHP programs</u>.**

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

*If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.*

2. **<u>Details for PCCM program</u>**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a._X_ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
a) We allow a limit of 1000 clients per PCP, however, we allow each provider to select his/her own limit to not exceed 1000 clients. The enrollment system has a lock in place to not allow the enrollment for any provider to exceed his/her preselected limit. Once that limit has been reached clients can be enrolled with him/her on a pending basis. This pending status allows the provider to agree or disagree to accept the client. If the client calls in to select the provider and the provider has reached the selected limit the client is informed of the "pending" status and what that means. If the provider does not choose to accept the increased caseload the client is sent a letter telling him/her to select another provider. If the limit has been reached, no one can be auto-assigned to that provider.

A client not currently enrolled who chooses a "pending" or "limited" provider is not required to get a referral for services until the client is actively enrolled with a provider. Therefore, the client is able to access all Medicaid covered services while on the "pending list"

A client currently enrolled with a provider in the Passport program and decides to change to a provider who is "limited". The client remains with the current provider through the end of the current month. At the beginning of the following month, the client would not be actively enrolled with a provider therefore, would not be required to get a referral for Medicaid covered services. The client would have access to all Medicaid covered services until they are actively enrolled again with another provider. There are no clients who do not have access to a provider.

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b) The limits are monitored periodically by running reports that list the providers with their limits and the actual number of clients. Providers are then sent letters or called on the phone to ask about increasing the selected limits. Also, on an individual basis, if it is noted that a provider has reached his/her limit and is having several clients requesting him/her as PCP, a letter or phone call is made asking the provider to increase the selected limit.

b._X_ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State's standard.

The department monitors potential provider access issues every six months with our network adequacy report. There have been no issues with access to PCP's in the State. The department reviews limited providers pending list semi annually to ensure that requesting clients are being notified of a decision regarding their choice of provider.

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c._X_ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity. The Department reviews the network adequacy report semi annually to ensure all participating counties have an adequate number of PCP's to ensure access to our Medicaid clients. To date there have been no issues concerning access in the state.

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d._X_ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

| | # Before Waiver | # In Current Waiver | # Expected in Renewal |
|---|---|---|---|
| Pediatricians | | 62 | 62 |
| Family Practitioners | | 227 | 227 |
| Internists | | 77 | 77 |
| General Practitioners | | 47 | 47 |
| OB/GYN and GYN | | 45 | 45 |
| FQHCs | | 12 | 12 |
| RHCs | | 35 | 35 |
| Nurse Practitioners | | 104 | 104 |
| Nurse Midwives | | 4 | 4 |
| Indian Health Service Clinics | | 9 | 9 |
| Additional Types of Provider to be in PCCM | | | |
| 1. Physician Assistant | | 66 | 66 |
| 2. Oncologist | | 17 | 17 |
| 3. Certified Nurse Specialist | | 2 | 2 |
| 4. General Surgery | | 8 | 8 |

*Please note any limitations to the data in the chart above here:
This listing is for the entire state. Montana's rural/frontier nature results in a limited number of specialists and sub-specialists throughout the state.

e X_ The State ensures adequate geographic distribution of PCCMs. Please explain.
We attempt to sign up all potential Passport providers in all counties. The quarterly Network Adequacy report lists all counties and any areas with a problem indicated on that report. No geographic areas have adequate distribution. Montana is a frontier state with only a limited number of specialists. This limitation is for our Passport clients as well as the population as a whole, regardless of their insurance status.

f.___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide

average. Please note any changes that will occur due to the use of physician extenders.

| *Area(City/County/Region)* | *PCCM-to-Beneficiary Ratio* |
|---|---|
| *Beaverhead* | *1 :71* |
| *Big Horn* | *1:18* |
| *Blaine* | *1:54* |
| *Broadwater* | *1:40* |
| *Carbon* | *1:20* |
| *Carter* | *1:14* |
| *Cascade* | *1:110* |
| *Choteau* | *1:20* |
| *Custer* | *1:33* |
| *Daniels* | *1:10* |
| *Dawson* | *1:45* |
| *Deer Lodge* | *1:56* |
| *Fallon* | *1:15* |
| *Fergus* | *1:47* |
| *Flathead* | *1:62* |
| *Gallatin* | *1:35* |
| *Garfield* | *1:20* |
| *Glacier* | *1:344* |
| *Golden Valley* | *0* |
| *Granite* | *1:18* |
| *Hill* | *1:132* |
| *Jefferson* | *1:23* |
| *Judith Basin* | *1:104* |
| *Lake* | *1:102* |
| *Lewis & Clark* | *1:53* |
| *Liberty* | *1:10* |
| *Lincoln* | *1:90* |
| *Madison* | *1:11* |
| *McCone (Not Implemented)* | *0* |
| *Meagher* | *1:18* |
| *Mineral* | *1:52* |
| *Missoula* | *1:83* |
| *Musselshell* | *1:42* |
| *Park* | *1:28* |
| *Petroleum* | *0* |
| *Phillips* | *1:64* |
| *Pondera* | *1:78* |
| *Powder River* | *1:22* |
| *Powell* | *1:46* |
| *Prairie* | *1:8* |

| | |
|---|---|
| *Ravalli* | *1:55* |
| *Richland* | *1:46* |
| *Roosevelt* | *1:165* |
| *Rosebud* | *1:71* |
| *Sanders (Not Implemented)* | *0* |
| *Sheridan* | *1:48* |
| *Silver Bow* | *1:79* |
| *Stillwater* | *1:39* |
| *Sweet Grass* | *1:13* |
| *Teton* | *1:25* |
| *Toole* | *1:48* |
| *Treasure* | *0* |
| *Valley* | *1:45* |
| *Wheatland* | *1:54* |
| *Wibaux* | *1:1* |
| *Yellowstone* | *1:68* |
| ***Statewide Average*** | *1:63* |

g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

**C. Coordination and Continuity of Care Standards**

1. **Assurances For MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Please note: The CMS Regional Office approved the original PAHP contract and is in the process of reviewing the contract amendment that extends disease management services through December 31, 2008.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

Our PAHP is for disease management services only. We do not have standards for capacity. We do, however, monitor the enrollment and caseload of DM clients on a monthly basis. If it ever appeared as if one DMO could not meet the capacity we would address it appropriately.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. ___ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d. ___ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.__ In accord with any applicable State quality assurance and utilization review standards.

e. ___ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. _X_ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. _ _ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. _X_ Each enrollee is provided health education/promotion information. Please explain.
During phone calls to the Medicaid help line clients receive education on the Passport program. Enrollees receive detailed information mailed to them upon initial enrollment to the program. We also have an online tutorial that educates clients.

d. _X_ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. _X_ There is appropriate and confidential **exchange of information** among providers.

f. _X_ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
It is expected that as part of the healthcare delivered by the PCP the client is informed of his/her health condition, follow-up and is given any training necessary. Although this is not specifically stated in our contract, it is part of providing healthcare.

g. _X_ Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
See f. above

h. _X **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

Our Passport providers are expected to provide case management through management of his/her client's care. Medical services which the primary care provider determines are necessary but cannot provide directly should be arranged (through referral) or authorized by the primary care provider. The primary care provider is required to document all referrals in the client's record or in a log book. The referral to the specialist or treating provider can be verbal or written.

i. _X_ **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Referrals are either verbal or written. We do not require that the primary care provider complete a written referral form. The primary care provider, does however, have to document the referral into the client's medical record or a log book. It is expected, as standard healthcare practices, that the referred to provider will notify the PCP of the results of any referral.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

**Section A: Program Description**

**Part III: Quality**

1. **Assurances for MCO or PIHP programs**.

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on _____.

___ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

| Program | Name of Organization | Activities Conducted | | |
|---|---|---|---|---|
| | | EQR study | Mandatory Activities | Optional Activities |
| MCO | | | | |
| PIHP | | | | |

2. **Assurances For PAHP program.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

**Our PAHP is for DM services only. We get monthly and quarterly reports that include clinical indicators and benchmarks.**

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. _X_ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

During the prior waiver period there was significant decrease in the monitoring of quality of services due to contract issues. We continued to monitor quality of services through the following means:

a) Access and Adequacy – Network Adequacy Report, Provider Type Listing Report, Client Survey, Complaints, Fair Hearing Requests, 24-Hour Call Log Report, Provider Change Report,
Change Enrollment Report. For details on the results of this

Monitoring see Section B.

b) In the previous waiver document we monitored Client Satisfaction - This is monitored indirectly through the Provider Change Report and Change Enrollment Report. It is monitored directly through the following means:

1) Client mail survey –We will send the survey to 1,000 randomly selected adults and 1,000 randomly selected children and their guardians on an annual basis. Follow-up is performed until we reach a confidence of 95 percent with a margin of error +/-5 percent. While one of our goals is to have a consistent survey that we can compare from year to year, we continue to make modifications to our survey to ensure the questions are formatted appropriately so they do not confuse the clients, and to ensure that we ask questions that are beneficial to our monitoring of the program.

This process will continue in the future and is anticipated to take place for 2008.

2) Complaint and Grievance – We continued with our comprehensive complaint and grievance policy over this waiver period. This policy is a fluid policy, allowing us to make changes as needed to ensure the policy works appropriately.

3) Comprehensive Overview Report of QA Activity - This comprehensive report will be provided quarterly and looks at all QA activity to determine if there is a trend among the QA activities which we should be concerned about. To date, we have not found population-wide issues, region-wide issues, quality of care issues or issues specific to one provider.

4) Other Activities – In addition to the Quality Assurance activities listed above we have two tools that will result in improved quality and utilization. These tools are the disease management programs, which have been in effect since January 2004 and available to all Passport clients. Clients are identified through claims inquiry and then sent a letter informing them of this no-cost program and how to access it. The clients who enroll are telephonically and in some cases assessed in person by Registered Nurses. The primary goal of these programs is to empower the clients to follow treatment plans directed by their providers and to educate them on healthier lifestyle behaviors targeted toward their disease processes. The other tool is client utilization reporting. Each Passport provider will receive quarterly reports of his/her client utilization patterns as well as information on specific clinical indicators.

b. _X_ **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. X Provide education and informal mailings to beneficiaries and PCCMs;

2. X Initiate telephone and/or mail inquiries and follow-up;

3. X Request PCCM's response to identified problems;

4. X Refer to program staff for further investigation;

5. X Send warning letters to PCCMs;

6. X Refer to State's medical staff for investigation;

7. X Institute corrective action plans and follow-up;

8. X Change an enrollee's PCCM;

9. X Institute a restriction on the types of enrollees;

10. X Further limit the number of assignments;

11. X Ban new assignments;

12. X Transfer some or all assignments to different PCCMs;

13. X Suspend or terminate PCCM agreement;

14. X Suspend or terminate as Medicaid providers; and

15. X Other (explain):
All of these steps are utilized in our identification and resolution of issues regarding access or quality of care. Once an issue is identified, the provider's medical records are requested and reviewed by the State.

If the issue appears to only be educational, this is provided. These providers or clients are then tracked for several follow-up quarters.

If there were to be definite quality of care issues involved, the case would be referred to physicians under consultation and the following procedure would be followed.

Physicians are given the complete case file and asked to review the information. A conference call or videoconference is held, the case is peer

reviewed and scored per protocol. Resolution of the case is a peer decision. The provider and/or client involved are informed of this process and the outcome. The process is held strictly confidential for all parties involved. The case is followed for a period of time determined by the physicians under consultation, and regular updates are given to the physicians. Each case is assessed individually and documentation is maintained and updated as needed.

During the current waiver period there have been no problems referred to a physician.

c. ___ **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. _X_ Other (please describe).
   Our fiscal intermediary, ACS, is responsible for signing healthcare providers as Montana Medicaid providers. If they meet the qualifications for Montana Medicaid, and are a provider type that has been identified as potential Passport PCP, they are eligible to be a Passport provider.

d. ___ **Other quality standards** (please describe):

**Section A: Program Description**

**Part IV: Program Operations**

**A. Marketing**

**Marketing** includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

Montana does not market Passport or Nurse First on radio, TV, in newspapers or in any form of advertising to the general population. We do market Passport and Nurse First to all potential Medicaid eligible clients with the General Medicaid Handbook for clients, when potential eligibles apply for Medicaid. Our enrollment broker markets the program through outreach activities through mail and telephone and internet. We provide Nurse First mailings to all eligible clients on a quarterly basis and as needed for their disease state. In addition, we intend to provide Passport and Nurse First information to all Medicaid providers through information in the monthly Medicaid Provider Claim Jumper Newsletter, provider website http://www:mtmedicaid.org, ACS provider trainings, provider manuals, and training at individual health care facilities. In addition, we occasionally send press releases about the Passport and/or Nurse First programs to media across the state.

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

**2. Details**
**a. Scope of Marketing**

1._X_ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers .

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. **Description**. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

**B. Information to Potential Enrollees and Enrollees**

1. **Assurances.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

**2. Details**

**a. Non-English Languages**

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State has not had a need to translate materials because we have no prevalent languages other than English. Montana has very few non-English speaking groups, none of which comprise 10 percent of the population. We are prepared to translate materials if there is a need. To date we have emailed one blind participant the Medicaid General Handbook so he could listen to the handbook through his computer.

The State defines prevalent non-English languages as:
(check any that apply):

1.__ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”

2. __ The languages spoken by approximately ___ percent or more of the potential enrollee/ enrollee population.
3.__ Other (please explain):

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.
Translators are available at no charge to clients who need translator services during the eligibility determination process or during the receipt of medical services.

__X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.
Clients can call the toll free Medicaid Help Line, access information on the Medicaid web site, and also receive Passport to Health information when they are enrolled. Providers and staff are also helpful in explaining the program to clients.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

___ State
X_ Contractor (please specify) __The enrollment process starts with Medicaid eligibility conducted at the local County Office of Public Assistance (OPA). Medicaid information and basic Passport information is given to all potentially Medicaid eligible clients. The information is given verbally by the Eligibility Case Manager and in the form of the General Medicaid Handbook.

The Passport Program has provided each OPA with a Passport Program video and encourages Eligibility Case Managers to show clients at the time of eligibility application.

The client receives a letter from the OPA when Medicaid eligibility is determined. The data for Medicaid eligible clients who have also been determined Passport eligible is then sent to the Contractor.

Passport staff has established effective communication patterns with the Public Assistance staff to emphasize a collective effort to better educate Medicaid clients. Passport staff attend various OPA County Director's meetings to present Passport Program information.

Nurse First clients are notified of their eligibility for the program through the OPA offices, the general Medicaid handbook, the Passport handbook, the Passport outreach calls, and mailings from the DMO.

Team Care clients are notified of their requirement to enroll in the Team care program through a mailing.

__ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

**c. Enrollee Information**

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State
(ii) _X_ State contractor (please specify):_See above__
(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

**C. Enrollment and Disenrollment**

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

Our DMO, McKesson, gets an eligibility file and a claims file at the beginning of each month. They send New Member Kits to each new eligible household. In addition, an analysis of the claims data is conducted and clients identified with the disease states are sent additional material. These identified clients also receive up to five telephone outreach attempts to educate them about the program and conduct assessments. The identified high cost/high risk clients who are in an area served by our Community Based Registered Nurses (CBRNs) also receive phone calls and face to face visits from these nurses.

In addition, the Nurse First programs are explained in the client handbooks, and all Passport brochures.

Client Passport Enrollment / Outreach After the client is determined Medicaid eligible at the County Office of Public Assistance a daily list of Passport eligibles is received by ACS. The concentrated positive outreach effort is conducted by ACS, for those clients eligible for Passport. On Day 1, ACS receives the data list of all Passport eligible clients new to Passport; clients with an address change requiring a change in provider, and clients who are reinstated in Medicaid after a change in Medicaid eligibility.

Outreach for enrollment is started Day 1 with the welcome letter and enrollment package sent out to all clients new to Passport or clients who have had a lapse of Medicaid eligibility of at least three months. Every effort is made to ensure that clients receive information making it possible for them to make an informed provider choice. An attempt is made to be respectful of client's provider history and geographical location. Automatic PCP assignment is done on day 30 of the outreach / enrollment process if no PCP has been chosen by the client.

The outreach performance standard for ACS is to successfully outreach 80 percent of those clients new to PASSPORT with telephones. This goal is always met and most months exceeded. Please see the Client Outreach Enrollment Process chart below.

| ***Client Outreach / Enrollment Process*** | |
|---|---|
| *Day 1* | *Receive client file from County (TEAMS).* |
| *Day 1-2* | *Send Client Welcome Letter and Enrollment Packet.* |
| *Day 5-10* | *1st Outreach/Enrollment Call or Attempt.* |
| *Day 10-15* | *2nd Outreach/Enrollment Call or Attempt.* |
| *Day 15* | *Send Client Reminder Letter if not yet enrolled.* |
| *Day 16-30* | *3rd Outreach/Enrollment Call or Attempt.* |
| *Day 30* | *Mail the Intent to Default or Automatic Assign Letter. (This event occurs once per month on the 11th or next business day of the month.)* |
| *Day 30 - 40* | *Outreach/Enrollment Call or Attempt to clients that have been assigned.* |
| *Day 40* | *Enrollments sent to TEAMS (OPA database) on the 6th to last working day of the month. (Cutoff Day)* |
| *Day 47-48* | *Beginning of next month - Enrollments take effect on the 1st of the new month.* |

*Note: In order to ensure that persons have sufficient time to choose a provider and voluntarily enroll with that provider, ACS allows a minimum of 30 days from the time a person is deemed eligible for managed care before assignment. The

monthly "cut off date" occurs about the 23rd of the month. If a client has been on managed care three months in the past, the individual is reinstated with their previous PCP.

**b. Administration of Enrollment Process**.

___ State staff conducts the enrollment process.

_X_ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

_X_ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: ____ACS_____

Please list the functions that the contractor will perform:

_X_ choice counseling
_X_ enrollment
_X__ other (please describe):

Other: The contractor's duties include maintaining the Medicaid Help Line. Clients may call the Medicaid Help Line for questions unrelated to Passport. The contractor's duties include providing general Medicaid information and phone referrals to other entities when necessary. Also included in the enrollment function would be exemption processing,

.

_X__ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process. For Nurse First Disease Management, McKesson enrolls eligible clients.

Medicaid clients identified as eligible for the Nurse First Disease Management Program are contacted by the contractor's team of specialized enrollment and assessment nurses and health resource counselors. The contractor sends letters explaining the Disease Management Program and why the clients have been selected for enrollment.

Contractor staff members attempt to reach all clients by telephone. If the nurses are able to reach clients by phone, they typically enroll about 90 percent of these clients. The nurses make a minimum of five call attempts over a two to three week period, leaving messages if not successful in reaching clients. If nurses are unable to make contact with clients by telephone, they send letters informing clients that nurses were unsuccessful with the calling attempts.

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**Deleted:** Please see program history in Section A, Part I for PCCM.

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The letters to clients contain contact information for clients to call or write for enrollment. Clients who cannot be reached may also be referred to field nurses or locators for additional attempts.

Clients are not considered enrolled until assessments have been completed by program nurses. If nurses are never able to make contact with clients for assessments, those clients are not actively managed by the contractor, but they do receive educational materials about their diseases.

Clients may opt out of the program at any time by calling the Nurse First Advice and Identification Line, by written notice to the contractor or to the State, by telling a telephonic or home visiting nurse they wish not to participate, or by having their medical providers advise the State or the contractor they wish to opt out.

Medicaid clients who have opted out of the Disease Management Program may enroll or re-enroll at any time by contacting the Medicaid Help Line, the disease management contractor, or the State Medicaid program.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

___ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

__ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. __ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

___ The State **automatically enrolls** beneficiaries
___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

_X_ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

1. TPL (Covers most medical needs and requires the client to choose a PCP.)
2. Out of state foster care/treatment center. –not eligible
3. Error correction/incorrect enrollment exemptions.
4. Provider leaves without 30 day notice.
5. Recipient moves to a non-Passsport county.- not eligible
6. Doctor refuses to see patient or give referrals.
7. Other ACS granted exemptions. NICU exemptions, …. "other" also listed to account for the unknown scenarios.
Client handbook outlines exemptions and informs clients to call Medicaid Help Line if they would like to request an exemption. Exempt treatment facilities and hospitals also are aware of exemption criteria and will inform ACS directly or advise the client to contact the Medicaid Help Line.
8. State granted hardship (would make it more difficult to get the medical care needed).

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The exemption process consists of the client, or his/her agent, requesting an exemption. The Department or ACS reviews the exemption request. Review consists of any or all of the following: review of claims, review of managed care history, phone conversations with medical providers, review of patient charts, phone conversation with client, etc. When a determination is made the client is notified via letter of the decision and notified of his or her right to appeal if the decision is negative. An exemption is granted for a period of time that accommodates the individual client and will usually be a period from 3 months to six months. A monitoring system is in place to review exemptions with the goal of ending the exemption when appropriate and enrolling the client with a PCP.

Team Care clients can not be exempt from the program but can request a fair hearing.

The Nurse First program is voluntary.

_X_ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

_X_ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i._X_ Enrollee submits request to State.

The plan may approve the request, or refer it to the State.

The plan may not disapprove the request.

Clients may change providers up to once per month without cause. Providers can request that a client be disenrolled for cause. The request from the provider must be in writing and should allow 30 days for the change to take place.

If a provider requests that a client be removed from his or her caseload after the 6th working day from the end of the month, we ask that the provider give care or referrals through the end of the following month. If the provider is unwilling we give the client an "emergency" exemption, which means the client can see any Medicaid provider that month without referral. The client's provider change information is entered into OmniTrack. The client is sent a letter instructing him or her to choose a new provider if the PCP initiated the change. A list of providers is enclosed with the letter. When a Passport provider leaves the Passport Program, all of his or her clients are disenrolled using the above procedure. ACS updates the provider information in the Passport database.

Team Care clients, however, must petition the Department or ACS to make a provider change. ACS and/or the Team Care program officer will review the circumstance of the request and determine if a change is warranted. Pharmacy changes take effect the first day of the next month after cut off unless extenuating circumstances require the pharmacy change to be immediate.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

___ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

_X_ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

___ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

_X_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

A provider may disenroll or terminate the provider-patient relationship, in accordance with the provider's professional responsibility by providing 30 days written notice to the recipient and to the Department.

The provider shall continue to provide patient management services for 30 days while the disenrollment is being completed. Only in certain circumstances will an exception be made to this rule. During this time the provider may either continue to treat the recipient or refer to another provider. Passport will assist the recipient in selecting a new PCP.

Disenrollment:
A provider may disenroll a Passport client for the following reasons:

- The provider-patient relationship is mutually unacceptable
- The client fails to follow prescribed treatment
- The client is abusive
- The client could be better treated by a different type of provider, and a referral process is not feasible

i._X_ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

ii._X_ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iii._X_ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

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**D. Enrollee rights.**

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

_X_ The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

**E. Grievance System**

1. X **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

___ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

___ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

__ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

___ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ___ days (between 20 and 90).

___ The State's timeframe within which an enrollee must file a **grievance** is __ days.

c. **Special Needs**

___ The State has special processes in place for persons with special needs. Please describe.

4. **<u>Optional grievance systems for PCCM and PAHP programs</u>**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

_X__ The State has a grievance procedure for its PCCM/PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:
_X__ the State
_X_ the State's contractor. Please identify: ____ACS_____
___ the PCCM
_X_ the PAHP.

_X__ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

We have one written policy regarding complaints and grievances. The difference between the complaints and grievances is explained in the following definitions:

Quality of Care (QOC) Complaint: Informal, verbal communication by a client or their authorized representative indicating that s/he wants the

opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate care or services received from the state, or any of its agents or providers under the Medicaid program. QOC reasons are listed below:

- *Had to wait too long for an appointment.*
- *Provider or staff did not explain things clearly.*
- *Provider or staff was rude.*
- *Not getting good medical care.*

General Complaint: Informal, verbal communication by a client or their authorized representative indicating that s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate service related to issues regarding eligibility, satisfaction with county or state agencies, or other similar matters not related to QOC concerns.

Formal Complaint: Written communication from a client or her/his authorized representative is a follow-up to a VERBAL complaint. This written communication is sent by the state to the client to confirm a complaint that was given verbally.

Grievance: Written communication which a client or her/his authorized representative presents indicating s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be an inappropriate action by the state or any of its agents or providers. This can be a QOC concern or a general concern.

Appeal: A request on behalf of a client for a review of an action taken on a complaint or grievance.

b._X_ Please describe any special processes that the State has for persons with special needs.

We will assist in filling out paperwork and have a TDD system for people with hearing deficiencies. We work with our clients on an individual basis and assist as needed whenever we can. If a client has a special need that cannot be met by us we may refer to the county office or to an advocacy

group. In either case we will work closely with the client and the other party to assist.

_X_ Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

The complaints typically come into the hotline that is staffed by our enrollment broker, ACS. The hotline staff initially and immediately review the complaint. If the complaint cannot be resolved immediately it is referred to the appropriate person. This can include state personnel or county personnel.

_X__ Specifies a time frame from the date of action for the enrollee to file a request for review, which is: ___90 days___ (please specify for each type of request for review)

This request is required for review of fair hearing decisions

_X__ Has time frames for resolving requests for review. Specify the time period set: __20 days____ (please specify for each type of request for review)

State has within 20 calendar days of receiving a complaint.

___ Establishes and maintains an expedited review process for the following reasons:_____ . Specify the time frame set by the State for this process____

_X_ Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

_X_ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. **Program Integrity**

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

_X_ The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

___ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

___ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604

Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

**Section B: Monitoring Plan**

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

| | |
|---|---|
| Program Impact | (Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems) |
| Access | (Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care) |
| Quality | (Coverage and Authorization, Provider Selection, Quality of Care) |

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

Network Adequacy Report – This report is a quarterly report. It lists the ratio on a county-by-county basis as well as a statewide ratio. The county ratios range from 1:344 to 1:10. The maximum capacity Montana Medicaid allows for each provider is 1000. We currently have 64% of all potential Passport PCPs as actual PCPs. We have begun further enhancements of our Network Adequacy report and will be able to have clearer information in the future.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

**I. Summary Chart of Monitoring Activities**

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under "Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

**The State's problems with past enrollment brokers have limited our reporting abilities. ACS will be reporting on the following charts during this waiver period. Our past enrollment broker PSI was not able to produce reliable reporting figures during the previous waiver period. However, historically we**

**have reported on the measures listed below and expect to continue to do so when ACS is fully operational.**

| Monitoring Activity | Evaluation of Program Impact | | | | | | Evaluation of Access | | | Evaluation of Quality | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Choice | Marketing | Enroll Disenroll | Program Integrity | Information to Beneficiaries | Grievance | Timely Access | PCP/Specialist Capacity | Coordination/ Continuity | Coverage/ Authorization | Provider Selection | Quality of Care |
| Accreditation for Non-duplication | | | | | | | | | | | | |
| Accreditation for Participation | | | | | | | | | | | | |
| Consumer Self-Report data | PCCM | PCCM | PCCM | | PCCM /PAHP | PCCM | PCCM | | PCCM | | PCCM | PCCM |
| Data Analysis (non-claims) | PCCM | PCCM | PCCM | PCCM | PCCM | PCCM | | PCCM | | | PCCM | |
| Enrollee Hotlines | PCCM | PCCM | PCCM | | PCCM /PAHP | PCCM /PAHP | PCCM | | PCCM | | PCCM | PCCM |
| Focused Studies | | | | | | | | | | | | |
| Geographic mapping | PCCM | | | | | | | PCCM | | | | |
| Independent Assessment | | | | | | | | | | | | |
| Measure any Disparities by Racial or Ethnic Groups | PCCM | | PCCM | | PCCM | | | | | | PCCM | |
| Network Adequacy | PCCM | | | | | | | PCCM | | | PCCM | |

| Monitoring Activity | Evaluation of Program Impact | | | | | | Evaluation of Access | | | Evaluation of Quality | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Choice | Marketing | Enroll Disenroll | Program Integrity | Information to Beneficiaries | Grievance | Timely Access | PCP/Specialist Capacity | Coordination/ Continuity | Coverage/ Authorization | Provider Selection | Quality of Care |
| Assurance by Plan | | | | | | | | | | | | |
| Ombudsman | | | | | | | | | | | | |
| On-Site Review | | | | | | | | | | | | |
| Performance Improvement Projects | | | | | | | | | | | | |
| Performance Measures | | | | | | | | | | | | |
| Periodic Comparison of # of Providers | PCCM | | PCCM | | | | | PCCM | | | PCCM | |
| Profile Utilization by Provider Caseload | | | | | | | | | | | | |
| Provider Self-Report Data | | PCCM | PCCM | PCCM | PCCM | | | PCCM | PCCM | | | |

**II Details of Monitoring Activities**

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

**The State's problems with past enrollment brokers have limited our reporting abilities. ACS will be reporting on the following charts during this waiver period. Our past enrollment broker PSI was not able to produce reliable reporting figures during the previous waiver period. For more detailed information please refer to program history at the beginning of this waiver document.**

**Below is listed what ACS will complete during this waiver period**

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ____ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. _X__ Consumer Self-Report data

___ CAHPS (please identify which one(s))
_X_ State-developed survey
___ Disenrollment survey

___ Consumer/beneficiary focus groups

d. __X__ Data Analysis (non-claims)
___ Denials of referral requests
_X_ Disenrollment requests by enrollee
___ From plan
_X_ From PCP within plan
_X_ Grievances and appeals data
_X_ PCP termination rates and reasons
___ Other (please describe)

e. _X___ Enrollee Hotlines operated by State

Hotline is operated by enrollment broker.

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. __X__ Geographic mapping of provider network

h. ____ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

i. __X___ Measurement of any disparities by racial or ethnic groups

j. _X__ Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

k. _____ Ombudsman

l. _____ On-site review

m. _____ Performance Improvement projects [**Required** for MCO/PIHP]
___ Clinical

___ Non-clinical

n. _____ Performance measures [**Required** for MCO/PIHP]
Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

o. __X___ Periodic comparison of number and types of Medicaid providers before and after waiver

p. ____ Profile utilization by provider caseload (looking for outliers)

q. _X__ Provider Self-report data
_X__ Survey of providers
We periodically survey providers.
___ Focus groups

r. __X___ Test 24 hours/7 days a week PCP availability

s. _X___ Utilization review (e.g. ER, non-authorized specialist requests)

t. _____ Other: (please describe

**Section C: Monitoring Results**

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

_X__ This is a renewal request.

_X_ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

__ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes
_X_ No. Please explain:

**The State's problems with past enrollment brokers have diminished our reporting abilities. ACS will be reporting during this waiver period. Our past enrollment broker PSI was not able to produce reliable reporting figures during the previous waiver period. For more detailed information please refer to program history at the beginning of this waiver document.**

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

**Section D – Cost-Effectiveness**

**Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section**. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

**Part I: State Completion Section**

**A. Assurances**

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Rick Yearry

c. Telephone Number:_____

d. E-mail: RYearry@mt.gov

e. The State is choosing to report waiver expenditures based on

___ date of payment.

__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

**B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test**—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

**C. Capitated portion of the waiver only: Type of Capitated Contract**

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b.___ PIHP
c._X_ PAHP
d.___ Other (please explain):

**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a._X_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
   1._X_ First Year: $ 3.00 _ per member per month fee
   2._X_ Second Year: $ 3.00 _ per member per month fee
   3._X_ Third Year: $ 3.00 _ per member per month fee
   4._X_ Fourth Year: $ 3.00 _ per member per month fee
b.___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

## E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
  1.___ Base year data is from the same population as to be included in the waiver.
  2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
_____

For Conversion or Renewal Waivers:

a._X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
See section A.I for explanation of decrease in member months.

d. _X_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: __There are none__

e._X_[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R2 is neither a state nor fiscal year. The dates are based on the previous waiver period. R2 runs from April 1, 2007 through June 30, 2007.

**F. Appendix D2.S - Services in Actual Waiver Cost**

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: _

There are no planned changes.

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _There were no excluded services

**G. Appendix D2.A - Administration in Actual Waiver Cost**

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

| Additional Administration Expense | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)* | *$54,264 savings or .03 PMPM* | *9.97% or $5,411* | *$59,675 or .03 PMPM P1*<br><br>*$62,488 or .03 PMPM P2* |

| | | | |
|---|---|---|---|
| Total | *Appendix D5 should reflect this.* | | *Appendix D5 should reflect this.* |

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._X_ Other (Please explain).

In Montana, two of our MEGs are PCCM and the third is a PAHP. The costs were first separated into PCCM (PPSSI/PPTANF) costs and DMPAHP costs by dividing all costs except the enrollment broker amount into thirds, so equal amounts of the remaining costs went to each MEG. The enrollment broker amount was applied to the PCCM MEGs (PPSSI/PPTANF). The amounts in each area were then applied on a PMPM basis.

**H. Appendix D3 – Actual Waiver Cost**

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

**Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections**

| 1915(b)(3) Service | Savings projected in State Plan Services | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *(Service Example: 1915(b)(3)* | *$54,264 savings* | *9.97% or* | *$59,675 or .03 PMPM P1* |

| | | | |
|---|---|---|---|
| *step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)* | *or .03 PMPM* | *$5,411* | *$62,488 or .03 PMPM P2* |
| Total | *(PMPM in Appendix D5 Column T x projected member months should correspond)* | | **(PMPM in Appendix D5 Column W x projected member months should correspond)** |

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

**Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections**

| 1915(b)(3) Service | Amount Spent in Retrospective Period | Inflation projected | Amount projected to be spent in Prospective Period |
|---|---|---|---|
| *(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)* | *$1,751,500 or $.97 PMPM R1*<br><br>*$1,959,150 or $1.04 PMPM R2 or BY in Conversion* | *8.6% or $169,245* | *$2,128,395 or 1.07 PMPM in P1*<br><br>*$2,291,216 or 1.10 PMPM in P2* |
| **Total** | **(PMPM in Appendix D3 Column H x member months** | | **(PMPM in Appendix D5 Column W x** |

| | | | |
|---|---|---|---|
| | **should correspond)** | | **projected member months should correspond)** |

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c._ _ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

**Current Initial Waiver Adjustments in the preprint**

**I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP**

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future).*

i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually**

**exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

***D.____Determine adjustment for Medicare Part D dual eligibles.***

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____ Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual

State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present)*. The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

**1.** List the State Plan trend rate by MEG from **Section D.I.I.a**._____

**2.** List the Incentive trend rate by MEG if different from **Section D.I.I.a**

_____

**3.** Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.
2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.
  i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
  ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

*Method:*

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1.___ Payments outside of the MMIS were made. Those payments include (please describe):
2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

*Basis and Method*:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.

3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.

4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

*Method:*

1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).

2.___ Determine copayment adjustment based on pending SPA.

3.___ Determine copayment adjustment based on currently approved copayment SPA.

4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

*Basis and method:*

1.___ No adjustment was necessary

2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.

3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4.___ The State made this adjustment:*

i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**

ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:

2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.

3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***

4.___ Other (please describe):

**Special Note section:**

**Waiver Cost Projection Reporting: Special note for new capitated programs**:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.

b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

**Special Note for initial combined waivers (Capitated and PCCM) only:**
**Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations --** Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

| Adjustment | Capitated Program | PCCM Program |
|---|---|---|
| Administrative Adjustment | The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column) | The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness). |

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

## J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. X **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while

other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2._X_ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. _X__ State historical cost increases. Please indicate the years on which the rates are based: base years April 1, 2006-March 31, 2007 and April 1, 2007-June 30, 2007. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3._X__The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
R1 and R2 (Complete quarters only) which runs from April 2006-June 2007

ii. Please document how the utilization did not duplicate separate cost increase trends.

See below.

b. _X__ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:**

These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._X_ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

***D.____Determine adjustment for Medicare Part D dual eligibles.***

***E.____*** Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi. X Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. _X_Other (please describe):

The adjustment was due to a trend analysis that was completed based on prior years for the State of Montana.

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A health care trend analysis is completed at the end of each year. This analysis is based on the prior three years. The inflation rate is calculated for each year and then average for the three years. This average inflation rate is the rate used in the calculation for this waiver.

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c.___ **Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base

years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

**1.** List the State Plan trend rate by MEG from **Section D.I.J.a** _____

**2.** List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

**3.** Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1. _X_ No adjustment was made.

1.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

**K. Appendix D5 – Waiver Cost Projection**

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

**L. Appendix D6 – RO Targets**

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

**M. Appendix D7 - Summary**

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

   **Please see section A-I program history for explanation of change.**

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   **Please see section A-I program history for explanation of change.**

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   **Please see section A-I program history for explanation of change.**

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

**Part II: Appendices D.1-7**

Please see attached Excel spreadsheets.

**Instructions for**

**Section 1915(b) Waiver Preprint**
**For**

- MCO, PIHP, PAHP, PCCM Programs

**And**

FFS Selective Contracting Programs

**July 18, 2005**
MMA amendment version

**Draft**

**Preprint Instructions**

**Introduction**

This waiver preprint is for a State's use in requesting authority under section 1915(b) of the Social Security Act (the Act) to operate a managed care program. Specifically, it is designed for use in authorizing programs involving Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Management (PCCM) systems. In addition, it can be used for section 1915(b)(4) fee-for-service selective contracting programs. Use of this 1915(b) waiver preprint is strongly encouraged.

Section 1915(b) of the Act, and 42 CFR 431.55, require that states assure waivers under this authority are cost-effective, and do not substantially impair access to services of adequate quality where medically necessary.

This waiver preprint is organized as follows:

| | |
|---|---|
| Face Sheet | Key Information |
| Section A | Program Description |
| Section B | Monitoring Plan |
| Section C | Monitoring Results |
| Section D | Cost effectiveness |
| Appendices D1-7 | Cost effectiveness data |

This preprint incorporates relevant statutory requirements (see sections 1902, 1903, 1915, and 1932 of the Act), as well as pertinent regulations (see 42 CFR Parts 431, 434, and 438). Please note that states must still have MCO contracts and capitation payments prior approved by the CMS Regional Office, and must have PIHP and PAHP contracts and capitation payments reviewed and approved by the CMS Regional Office.

This preprint is not for use in authorizing managed care programs under sections 1905(t), 1915(a), or 1932(a) of the Act. Programs under those authorities are authorized through state plan amendments.

**Features**

This waiver preprint is designed to simplify the waiver application process. It has the following features:

- Use same document for initial and renewal. The State may use this waiver preprint to make an initial request to authorize a new 1915(b) waiver program, or to request a renewal or amendment of an existing one. In addition, Sections A and B (Program Description and Monitoring Plan) need not be resubmitted at each renewal if there are few or no changes.
- Authorize multiple programs. The preprint is flexible enough to be used to authorize multiple managed care programs under a single waiver request. However, it is up to States to determine how many waiver programs they want to authorize in a given waiver request.
- Reduce duplication with other requirements. Federal regulations in 42 CFR 438 provide clear and consistent requirements related to beneficiary protections for all

types of managed care programs; and for access and quality for capitated programs. As a result, in many places assurances of compliance with regulatory requirements will be sufficient to comply with waiver requirements related to Program Impact, Access, and Quality. Additional information may be required if a State requests a waiver of a provision within the regulation.

- Provide clear evaluation criteria. The preprint provides clear direction on the information needed and criteria used to evaluate waiver requirements related to Program Impact, Cost Effectiveness, Access, and Quality.

**How to submit**

What to include in submission. For initial or renewal requests, submit the items below. For amendments, see the next section.

- Signed cover letter (from the Governor, state cabinet members responsible for state Medicaid activities, the Director of the state Medicaid agency, or someone with authority to submit waiver requests on behalf of the Director)
- Face sheet
- Sections A-D (as applicable; see below)
- Appendices D1-7 (as applicable; see below)
- Any other state-specific attachments.

Number of copies/format. Please submit the following to the CMS Central Office:

- One original hard copy of the waiver preprint and attachments
- One electronic copy of the waiver and any attachments available electronically
- Four (4) copies of any waiver attachments not available electronically

At the same time, send at least one hard copy of the waiver request to the appropriate CMS Regional Office.

Where to send. For MCO programs, PCCM programs, PAHP programs covering dental or transportation services, and FFS selective contracting programs:

CMS, Center for Medicaid and State Operations
Attn: Director, FCHPG, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

For PIHP/PAHP programs focusing on behavioral health, or on elderly and disabled populations:

CMS, Center for Medicaid and State Operations, DEHPG
Attn: Director, Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244

Processing timelines. CMS must approve, disapprove, or request additional information for a waiver request submitted under section 1915(b) of the Act within 90 days of receipt, or else the request is deemed granted. When CMS requests additional information, the

waiver request must be approved or disapproved within 90 days of CMS' receipt of the State's complete response to the request for additional information, or the waiver request is deemed granted. The 90-day time period begins (i.e., day number one) on the day after the day the State's waiver or response to request for additional information is received by the addressee (i.e., the Secretary, the CMS Central Office, or CMS Regional Office designee) and ends 90 calendar days later.

**When Amendment Needed During Waiver Period**

The State must submit an amendment for major changes, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, PCCM quality/access, monitoring plan, changes in payment rates, or changes in costs or trends that may jeopardize cost-effectiveness. Please submit replacement page(s) for relevant changes.

The same timelines and procedures described in the "How to Submit" section above apply to waiver amendments. Approval of a request to amend the waiver is effective from the date of approval through the end of the renewal period. The request must be submitted and approved prior to implementation of a change in the waiver program.

**Instructions for Filling Out Sections A, B, and C**

General instructions for filling out Sections A, B, and C are below. Each Section may have more detailed instructions. The preprint clearly indicates if a given item only applies to a certain type of managed care entity. If a given item does not apply, the State should indicate this by inserting "not applicable."

Assurance of compliance with requirements. The preprint includes assurances with compliance with applicable federal statutory, regulatory, and policy requirements related to managed care.

*Exception*: If the State is requesting a waiver of a provision of a federal managed care requirement, it must add language at the end of the assurance stipulating the waiver being requested, and what, if anything, the State will do instead.

Detail on discretionary items. In areas where the State has discretion, the State must describe what method it uses. For example, 42 CFR 438.10(c)(1) requires the State to identify prevalent non-English languages, but gives the State discretion in what methodology to use. For PCCM programs, the State has broader discretion in demonstrating how the waiver program impacts access and quality, so must describe in detail the standards and processes it uses.

Initial waiver request. If this is an initial waiver request, the State should fill out Sections A (Program Description), B (Monitoring Plan), D (Cost-Effectiveness) and Appendices in full. In Section C (Monitoring Results), the State must assure that in the renewal request, it will submit the results of its monitoring activities.

Renewal waiver request -- converting to new preprint. If this is the first time a State is using this preprint format, the State should fill out the preprint in full.

Renewal waiver request – once new preprint has been used. If the State has used this format for the previous waiver period, the State should fill out Sections C and D (Monitoring Results and Cost-Effectiveness) and Appendices D1-7 of the preprint in full. With respect to Sections A-B (Program Description and Monitoring Plan), the State has two options:

Option 1 – Submit sections in full. The State may want to consider this if there are numerous changes from how the program was operated and/or monitored compared to the previous waiver period.

Option 2 – Carry over from previous waiver period. If there are few or no changes to the Program Description or Monitoring Plan, the State need not re-submit these sections. Instead, it can indicate it will use the same Sections from the previous waiver period, and if needed, submit replacement pages for minor changes.

The State may choose different options for Section A versus Section B. Please indicate on the Facesheet which option the State uses.

Single program. Many areas of the preprint apply to all entity types (e.g. enrollment, information). However, if a given section does not apply to the type of entity in a single program waiver, please respond by inserting "Not Applicable."

Multiple programs. This preprint can be used for a combination of capitated and PCCM programs. However, not all programs will fit each item, or the answer to a given item may be different for PCCM versus a capitated program. If the State's response differs for either the capitated or PCCM program, please check the box if applicable and add narrative below to describe to which program(s) the checked box applies and how.

FFS selective contracting programs. If a State is only using section 1915(b)(4) authority to selectively contract FFS providers (i.e. who do not qualify as an MCO, PIHP, PAHP, or PCCM), the portions of the preprint that require assurances with managed care regulations and contracts do not apply. However, the State must still address program impact, access, and quality, though they have discretion in how to do so. Please fill in the "1915(b)(4) FFS selective contracting" items within each section.

**MMA 1915(b) Amendment Instructions**

Any drug costs for Dual Eligibles that are in the waiver cost-effectiveness and no longer covered by Medicaid will need to be adjusted out of the 1915(b) waivers as of 1/1/2006.

Option 1: You may do this through a Waiver renewal submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1

adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

or

Option 2: through an extra amendment to your waiver submitted for an effective date on or before January 1, 2006. To do this, the State would have an additional P1 adjustment on Appendix D5, just add 2 columns to document. The adjustment would be noted on the updated preprint at pages 15, 67, 72, 73, 77, 78, and 81. In addition, please note on Appendix D2.S the drug costs for the Dual Eligibles that have been excluded.

Qs and As from States regarding the modification to 1915(b) waivers

Q1: Since Medicaid must pay the federal government back for the amount of drug payments that Iowa paid for dual eligibles in 2003 after implementation of Medicare modernization, we are not sure that there will be any less amount that Medicaid paid for drugs. It is more indirect than before when Medicaid paid the costs directly, but the incidence is for drugs when we have to pay back the federal government. Also we will lose the drug rebate for the drugs we paid, which again we think may mean no savings to Medicaid for Medicare paying drugs for the dual eligibles.

A1: The calculation of state contribution and the overall cost to the State will not count against the waiver cost-effectiveness in future 1915(b) waivers. These are separate calculations.

**Instructions for Filling Out Section D – Cost Effectiveness**

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. Instead, States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

The 1915(b) Cost-Effectiveness Instructions are divided into 3 major sections:

| | |
|---|---|
| Section I. | Definitions and Terminology |
| Section II. | General Principles of the Cost-Effectiveness Test |
| Section III. | Instructions for Appendices |

In addition there are seven Appendices:

| | |
|---|---|
| Appendix D1. | Member Months |
| Appendix D2.S | Services in the Actual Waiver Cost |
| Appendix D2.A | Administration in the Actual Waiver Cost |
| Appendix D3. | Actual Waiver Cost |
| Appendix D4. | Adjustments in Projection |
| Appendix D5. | Waiver Cost Projection |
| Appendix D6. | RO Targets |
| Appendix D7. | Summary Sheet |

**States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint.** The Appendices included with the Preprint have been filled in with a completed actual example from the State of Nebraska. Each State should modify the spreadsheet to reflect their own program structure and replace the Nebraska information with its own data. *Note: the example is for illustrative purposes only. It does not reflect Nebraska's actual experience or program structure.*

In addition, technical assistance is available through each State's CMS Regional Office. Each Regional Office has a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests.

**Actual Waiver Service Cost + Actual Waiver Administration Cost<= Projected Waiver Cost**

## I. Definitions and Terminology

The following terms will be used throughout this document and are defined below:

**For Initial Waivers:**
Historical Period
- BY = Base Year

Projected Waiver Period
- P1 = Prospective Year 1
- P2 = Prospective Year 2

**For Conversion Waivers *(existing waivers which will "convert" from the former "with and without waiver" cost effectiveness test to the new cost effectiveness test described in these instructions)*:**
Historical Period for first time a State completes the new cost effectiveness test
- BY = Base Year – CMS prefers 7/1/2001 – 6/30/2002

Projected Waiver Period
- P1 = Prospective Year 1
- P2 = Prospective Year 2

**For Renewal Waivers:**
Retrospective Waiver Period

- R1 = Retrospective Year 1
- R2 = Retrospective Year 2 – Project forward from end of R2 using experience/trends from R1 and R2

Projected Waiver Period

- P1 = Prospective Year 1
- P2 = Prospective Year 2

**Form CMS-64:** *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program* (MBES - formerly known as the HCFA-64) submitted by States as an accounting statement under Title XIX and Title XXI of the Social Security Act. The *Form CMS 64* is completed according to the reporting instructions in the State Medicaid Manual, Section 2500. Additional technical assistance is available through each State's CMS Regional Office. Each Regional Office will have a guide providing additional information regarding the procedures and policies for developing cost-effectiveness documentation for 1915(b) waiver requests. In general, CMS-64 data is recorded based on the date that a payment was made to a provider.

**Form CMS-64 Summary and CMS-64.9:**
The *Form CMS-64 Summary* is an accounting of all expenditures for Medical Assistance **services and administration** for both MAP (CMS-64.9) and ADM (CMS-64.10) under Medicaid Title XIX and Title XXI Medicaid Expansion Groups including waiver expenditures. The Summary Sheet is generated from all worksheets entered by the State in support of each line item (including prior period adjustments). The *CMS-64.9* reports current expenditures for Medical Assistance **services** under the non-waiver programs.

**Form CMS-64.10:** The *Form CMS-64.10* is an accounting of **administrative** expenditures in Medicaid Title XIX for non-waiver programs.

**Form CMS-64.21U:** The *Form CMS-64.21U* is an accounting of **service and administrative** expenditures for the State Medicaid Expansion portion of the Children's Health Insurance Program (SCHIP) Title XXI. This form reports expenditures for children covered under 1905(u)(2) and (u)(3) of the Social Security Act.

**Form CMS-64 F:**
The *CMS-64 F Form* recaps all *CMS-64.21 Medicaid Expansion Forms* and Medicaid *CMS 64.9 Forms*. The *CMS-64 F Form* is summarized in the *CMS-64 Summary Form*. The *CMS-64 F* describes the source of the data on each line of the *CMS-64 Summary*. An example follows:
*CMS-64 Summary*, Line 6 MAP = $100
*CMS-64 F*, Line 6 MAP, *Form CMS-64.9* = $80
*CMS-64F*, Line 6 MAP, *Form CMS-64.21* = $20

**Form CMS-64.9 Waiver:** Same as the *Form CMS-64.9* except the *Form CMS-64.9 Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver program. The State will provide separate *CMS-64.9 Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.9 Waiver forms* will

contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.9 Waiver form* for expenditures that are not included on other *64.9 Waiver forms*. The *CMS-64.9 Waiver forms* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.9 Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.9 Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.9 Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.9 Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instruction section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the following Standard 1915(b) Waiver coding system:

- State Code: This will be the State's two-digit identifier (e.g., CA, FL, PA);
- Two digit waiver number;
- Followed by the two-digit waiver renewal number; and
- Followed by the two-digit consecutive waiver year.

Please work with your RO if you need guidance identifying this number. *Example: The Iowa Plan reporting for a waiver renewed on July 1, 2001 would use: IA07.R02.05. The Iowa Plan is Iowa's seventh waiver. It was renewed for the second time on July 1, 2001. If the first year of their waiver began July 1, 1997, the waiver year beginning July 1, 2001 would be 05.*

| | |
|---|---|
| State Code | IA |
| Two-digit waiver number | 07 |
| Two-digit waiver renewal number | 02 |
| Two-digit consecutive waiver year | 05 |

**Form CMS-64.9P Waiver:** Same as the *CMS-64.9 Waiver* except reporting a prior period adjustment.

**Form CMS-64.10 Waiver:** Same as the *Form CMS-64.10* except the *Form CMS-64.10 Waiver* reports Administration costs only for the population and services covered by the State's 1915(b) waiver program. The State will provide separate *CMS-64.10 Waiver forms* for each 1915(b) waiver program. The State must report administrative costs attributable to each waiver program on separate *CMS-64.10 Waiver forms*. Administrative costs that are applicable to more than one waiver program must be allocated to the respective *CMS-64.10 Waiver forms* based on a method approved by CMS (e.g., allocation based on caseload or Medical Assistance payments). Therefore, the

*CMS-64.10 Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If the State has specific questions regarding this requirement, please contact your State's RO. To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system. *Note: States should document their cost allocation methodology for administration costs between waivers in D.I.G.*

**Form CMS-64.10P Waiver:** Same as the *CMS-64.10 Waiver* except reporting a prior period adjustment.

**Form CMS-64.21U Waiver:** Same as the *Form CMS-64.21U* except the *Form CMS-64.21U Waiver* reports Medical Assistance service payments only for the population and services covered by a State's waiver programs. Cost Effectiveness requirements apply only to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular programmatic aspect of their FFS or managed care program. The State will provide separate *CMS-64.21U Waiver forms* for each 1915(b) waiver program. Therefore, the *CMS-64.21U Waiver forms* will contain data that is a subset of the data contained in the *Form CMS-64 Summary*. If a beneficiary is enrolled in more than one waiver program (e.g., a comprehensive MCO risk contract and a separate PIHP for mental health services), the State reports costs for each beneficiary impacted by each waiver on a *CMS-64.21U Waiver form* for expenditures that are not included on other *64.21U Waiver forms*. The *CMS-64.21U Waiver sheets* are mutually exclusive, meaning that expenditures must not be counted twice. Multiple *CMS-64.21U Waiver forms* may be appropriate for a waiver. For instance, the State may choose to have multiple Medicaid Eligibility Groups (MEGs) for each waiver and can use a separate form for each MEG – provided that the expenditures are not included on other *64.21U Waiver forms*. If the costs for a certain population includes beneficiaries which are impacted by both an 1115 demonstration and a 1915(b) waiver, the State will report the costs for that particular population (including only beneficiaries impacted by both an 1115 demonstration and a 1915(b) waiver) on a single, separate *CMS 64.21U Waiver form* that will be reported once, but counted in both cost test analyses. The separate *CMS 64.21U Waiver form* should be clearly identified as impacting both the 1115 demonstration and 1915(b) waiver. See the specific instructions in the CMS 64 instructions section in the Technical Manual for that circumstance. If the State has specific questions regarding this requirement, please contact your State's Regional Office (RO). To enhance the CMS-64 Waiver tracking, the State should report their expenditures for the population covered under their waiver using the Standard 1915(b) Waiver coding system.

**Form CMS-64.21UP Waiver:** Same as the *CMS-64.21U Waiver* except reporting a prior period adjustment.

**Schedule D:** Schedule D is a report of waiver expenditures by waiver year for a given waiver period that is generated within the Medicaid Statement of Expenditures for the Medical Assistance Program (MBES) when selected by an MBES user from the reports menu. The State will submit a Schedule D for the previous waiver period with each renewal submission.

**Base Year:** In an Initial Waiver (i.e., first submission of a new program's cost-effectiveness data), CMS requires all States to create a BY which can be used to project total expenditures for the projected waiver period (P1 and P2). The BY must be the most recent year that has already concluded. The State must justify the use of any other year as the base year. All expenditures in the BY will be verified by the RO. The BY expenditure and enrollment data should be the actual experience specific to the population covered by the waiver. The maximum time period between a BY and P1 should be five years. CMS recommends that States use the first day of a Federal quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

**Base Year for Conversion Waivers:** In Conversion Renewal Waivers (i.e., existing 1915(b) waivers which will comply with these cost-effectiveness instructions ***for the first***), CMS will require all States to create a BY which can be used to project total expenditures for the projected waiver periods (P1 and P2). If possible, the BY should be a year which has already concluded and where no additional payments can be recorded. All expenditures in the BY will be verified by the RO. CMS prefers that states use 7/1/2001 – 6/30/2002 as their BY because it was prior to the announcement of the new test and would not allow states to increase costs after the announcement that there would be no retrospective review for the conversion renewal period. That base year is also complete and allows states to begin analysis in order to submit their waivers in a timely manner. If the State would like, CMS will negotiate a BY that has already been concluded other than 7/1/2001 – 6/30/2002. For waivers just renewed in 2003 under the old methodology, if a State begins reporting waiver expenditures by MEG in a timely fashion, the State may have a full year of data on the MBES system via the CMS-64 Waiver forms by the time the waiver is renewed in 2005. If this is the case, the State could use the Schedule D information for a waiver year in the most recent waiver period to complete their upcoming renewal. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to adding into waiver cost projections.*

**Caseload:** The total number of individuals enrolled on a waiver at any given time is its caseload. Because cost-effectiveness is calculated on a PMPM, the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload. The standard measurement for caseload is member months.

**Case mix:** The payments and the PMPM costs of a waiver program are affected by the distribution of the caseload among different reporting categories (MEGs in a 1915(b) waiver). The relative distribution of a member months among MEGs is referred to as membership mix or "case mix". Anytime a State has a MEG with greater than average cost and a caseload growing at a faster rate than less expensive MEGs, the overall weighted average should account for casemix changes or there will be a false impression of the waiver not being cost-effective. *For example, in a State with 100 enrolled members, MEG 1 has a PMPM cost of $3,000 and has 25% of the member months (25 member months) in the base year. MEG 2 has a PMPM cost of $300 and has 75% of the member months (75 member months) in the base year. The overall weighted PMPM for BY with the base year casemix would be:*

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{BY PMPM x BY MM}}{\text{BY MM}}$ =BY PMPM With Casemix for BY

*The State projects that the casemix and costs will remain the same in the future (P1). However, if in P1, the program's casemix changes so that MEG 1 has 30% of the member months and MEG 2 has 70% of the member months in P1. The overall weighted PMPM for P1 with the P1 casemix would be:*

$\frac{(\$3000 \times 30) + (\$300 \times 70)}{100} = \$1{,}110$ $\frac{\text{P1 PMPM x P1 MM}}{\text{P1 MM}}$ =P1 PMPM With Casemix for P1

*In this case, because MEG 1 has a high cost, a relative distribution change from MEG2 to MEG 1 artificially inflates the PMPM if the State does not account for the changes in the casemix*. The overall weighted PMPM for P1 with Casemix for BY

$\frac{(\$3000 \times 25) + (\$300 \times 75)}{100} = 975$ $\frac{\text{P1 PMPM x BY MM}}{\text{BY MM}}$ =P1 PMPM With Casemix for BY

Throughout this document, CMS has explained when to account for casemix changes and how to calculate those calculations. In determining whether to renew the waiver, States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. However, for the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one which accounts for casemix changes (to monitor for PMPM waiver cost-effectiveness) and another which does not account for casemix changes (to monitor for overall growth in CMS-64 expenditures). These calculations are projected in Appendix D6 and explained in the instructions and Technical Assistance Guide.

**Medicaid Eligibility Group (MEG) -** A MEG is a population reporting category usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Each State will have at least one Title XIX MEG for a Medicaid 1915(b) waiver. If the State includes MCHIP populations under 1905(u)(2) and/or (u)(3) in the 1915(b) waiver, then the State will also have at least one Title XXI MEG. Each MEG's costs will be reported on a separate 64.9 Waiver Form (64.21U Waiver Form if the MEG is for an MCHIP population). States are held accountable for member month distribution changes within MEGs, but not between MEGs. In cases where significantly different costs exist between different populations, the State should consider separate MEGs to account for the likelihood of a change in the

proportion of the enrollees being served in any single reporting group. The State should recognize the impact on cost trends of the increase in the proportion of membership, which would be associated with the higher cost group when determining cost-effectiveness. The State may want to consider a more complex reporting structure, which would attempt to recognize high-cost groups separately from low-cost groups. It is in a State's interest to group populations with similar costs and similar caseload growth together. *For example, a State has a program with 100 member months - 25% of which cost $3,000 and 75% of which cost $300. The State can choose to have a single MEG with a PMPM cost of $975 or two MEGS with a weighted PMPM of $975. If the State has a distribution shift between the two population groups so that there are relatively more expensive persons costing $3,000, the State will be held accountable for that redistribution effect if it has only one MEG and will not be held accountable if the State has two MEGS. The weighted-average PMPM Casemix for BY for the single MEG is $1,110. The weighted-average PMPM Casemix for BY for two MEGs is $975.*

*One MEG*

| *Base Year PMPM Casemix BY* | | P1 PMPM Casemix BY | |
|---|---|---|---|
| *($3000 x 25) + ($300 x 75) / 100* | *= 975* | *($3000 x 30) + ($300 x 70) / 100* | = $1,110 |
| BY PMPM x BY MM / BY MM | =BY PMPM With Casemix for BY | P1 PMPM x P1 MM / BY MM | =P1 PMPM With Casemix for BY |

*Two MEGs*

| *Base Year PMPM Casemix BY* | | P1 PMPM Casemix BY | |
|---|---|---|---|
| *($3000 x 25) + ($300 x 75) / 100* | *= 975* | *($3000 x 25) + ($300 x 75) / 100* | = 975 |
| BY PMPM x BY MM / BY MM | =BY PMPM With Casemix for BY | (P1 PMPM x BY MM) + (P1 PMPM x BY MM) / BY MM | =P1 PMPM With Casemix for BY |

**Adjustments:** Each State creates budget projections in a slightly different manner than other states. To address this, CMS has identified the most common adjustments states make to base year data (in initial and conversion waivers) and R2 data (in renewal waivers). The State must document each adjustment made, what is meant by each adjustment in the State Completion Section, how that adjustment does not duplicate another adjustment made, and how each adjustment was calculated. For example, in the State Completion section, the State is asked to document the State Plan Services Trend Adjustment. The State Plan Services Trend Adjustment reflects the expected PMPM cost and utilization increases (e.g., service prices, practice patterns, and technical innovation) in the managed care program from R2 (BY for initial/conversion waivers) to the end of the waiver (P2). Trend adjustments may be State Plan service-specific. Adjustments are typically expressed as percentage factors. Some states calculate utilization and cost

increases separately, while other states may calculate a combined trend rate. Because the trend is expressed on a PMPM basis, the State should explain what is accounted for in the trend adjustment (i.e., cost and utilization increases). Any trend should not be duplicated in the State's adjustments for programmatic/policy/pricing adjustments. For example, a Legislative price increase would be explained and reflected in the programmatic/policy/pricing adjustment not under the State Plan Services Trend Adjustment. The State should document how the adjustments are unique and separate.

**Trend:** Growth in spending from one year to the next year. Growth may be due to cost and utilization increases. Growth due to external forces such as Legislative change or program/contract change should be documented separately under adjustments that include more than trend. If only a trend adjustment is allowed, then growth due to external forces is not allowed without a separate waiver amendment documenting additional savings. In this preprint, all adjustments are made on a PMPM basis. For the sake of simplicity, whenever trend appears alone it refers to a PMPM increase in the cost.

**Comprehensive Waiver Criteria:** When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test: 1) Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority; 2) Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc); or 3) State Plan services were procured using sole source procurement.

**Expedited Test:** States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. To be able to use the Expedited Test for a particular waiver, a State would need to submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria (see above) OR Submit a 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver, which meets the Comprehensive Waiver Criteria except for the transportation and dental waivers specifically exempted.

**Projections in Renewal Waivers:** In Renewal Waivers, State will use its actual experience R1 and R2 data to project its P1 and P2 expenditures from the endpoint of the previous waiver of R2. In each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2. CMS recommends that States use the first day of a quarter as the effective date for 1915(b) waivers to simplify the process of using CMS-64 Waiver submissions in demonstrating cost-effectiveness. If this is not possible, States must use the first day of a month as the effective date.

**Projected Waiver Period:** P1 and P2 are projections of the Medicaid waiver program expenditures for the future two-year period for the population covered by the waiver.

**Retrospective Waiver Period:** R1 and R2 are the actual Medicaid waiver program expenditures in the historical two-year period for the population covered by the waiver. These R1 and R2 costs are compared to the P1 and P2 projections from the previous waiver submission. *Note: For the first renewal of an initial waiver or the first time that a State uses the new method, actual administration and service costs must be verified by the RO prior to developing waiver cost projections.*

**1915(b)(3) service:** An additional service for beneficiaries approved under the waiver paid for out of waiver savings. The service is not in the State's approved State Plan. Capitated 1915(b)(3) services must have actuarially sound rates based only on approved 1915(b)(3) services and their administration subject to RO prior approval.

Acronyms used in this section
ADM - Administration
AI/AN – American Indian/Alaskan Native
BBA – Balanced Budget Act of 1997
BY – Base Year
CAP - cost allocation plan amendment
CE – Cost Effectiveness
CMS – Center for Medicare & Medicaid Services
Co. - County
CSHCN – Children with Special Health Care Needs
CY – Calendar Year
DRG - Diagnostic Related Group
DSH - Disproportionate Share Hospital Payments
EQR – External Quality Review
FFP – Federal Financial Participation
FMAP – Federal Medical Assistance Participation
MAP – Medical Assistance Program or services
FFS – fee-for-service
FQHC – Federally Qualified Health Center
FY- Fiscal Year
GME – Graduate Medical Education
HIO – Health Insuring Organization
MBES - Medicaid Statement of Expenditures for the Medical Assistance Program
MCO – Managed Care Organization
MCHIP – Medicaid-Expansion Children's Health Insurance Program
MEG – Medicaid Eligibility Group
MMIS – Medicaid Management Information System
P1 – Prospective Year 1
P2 – Prospective Year 2
PAHP -- Prepaid Ambulatory Health Plan
PCCM – Primary Care Case Manager
PIHP – Prepaid Inpatient Health Plan
PMPM – Per Member Per Month

RHC – Rural Health Center
SPA – State Plan Amendment
PRO – Peer Review Organization
Q1 – Quarter 1
Q4 – Quarter 4
Q5 – Quarter 5
R1 – Retrospective Year 1
R2 – Retrospective Year 2
RO – Regional Office
SCHIP – State Children's Health Insurance Program
SURS - Surveillance and Utilization Review System
Title XIX – Medicaid
Title XXI - State Children's Health Insurance Program
TPL – Third Party Liability
UPL – Upper Payment Limit

## II. General Principles of the Cost-Effectiveness Test

Cost-effectiveness is one of the three elements required of a 1915(b) waiver. In order to grant a 1915(b) waiver, a State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. The State will document program expenditures on the CMS- 64 for the same two-year period for the population covered by the waiver. In other words, a State initially projects spending and documents on an on-going basis that the actual expenditures are at or below the projected amount.

In order for CMS to renew a 1915(b) waiver, a State must demonstrate that it was cost-effective during the retrospective two-year period and must create waiver cost projections that will be used to determine cost-effectiveness for the prospective two-year period. The cost-effectiveness test is applied to the combined two-year waiver period, not to each individual waiver year or portion of a year.

The Cost Effectiveness test for 1915(b) waivers will no longer rely on a comparison of "with waiver" and "without waiver" costs. States no longer need to demonstrate that "with waiver" costs are lower than "without waiver" costs. Instead, States must demonstrate that their waiver projections are reasonable and consistent with statute, regulation and guidance. Retrospectively, the State will document that program expenditures were less than or equal to these projections. As with all elements of 1915(b) waivers, States may amend their cost-effectiveness projections if the waiver program changes or if additional information documents that the projections are inaccurate and should be modified accordingly.

Each Initial Waiver submission will include a State's projected expenditures for the upcoming two year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2).

For each Renewal Waiver submission, a State will demonstrate cost-effectiveness for the retrospective waiver period by showing that the actual expenditures for retrospective years one and two (R1 and R2) did not exceed what the State had projected it would spend (P1 and P2) for the same two-year period on a per member per month (PMPM) basis for the population covered by the waiver. In other words, a State must compare what it had initially projected it would spend to what it actually spent over the waiver period and show that the actual expenditures came in at or under the projected amount. *Please note that for Conversion Waivers, CMS will not require a retrospective cost-effectiveness test. The State is only allowed a single Conversion Waiver, the first time the State submits a waiver renewal after the announcement of this new method.*

In order to project expenditures for the prospective waiver period, a State must use the actual historical expenditures from its base year (for an initial or conversion waiver) or from the past waiver period (R1 & R2 for a renewal waiver) as the basis for its cost effectiveness projection, adjusting for future changes in trend (including utilization and cost increases), and other adjustments acceptable to CMS. By always using actual historical expenditures from the most recent waiver period as the basis for the projection, the cost-effectiveness test for a waiver program will be "rebased" upon each renewal. *Note: this applies to both capitated and FFS services within 1915(b) waivers. The State must document that actual costs claimed on the CMS-64 were used to document the Actual Waiver Cost in Appendix D3.*

All 1915(b) waivers will use this cost-effectiveness test, regardless of the type of waiver program or the delivery system under the waiver.

All Medicaid Medical Assistance program expenditures (fee-for-service and capitated services) related to the services covered by the waiver will be reported for the population enrolled in the waiver. Because waiver providers can affect the costs of services not directly included in the waiver, CMS is requiring that States include **all Medicaid Medical Assistance program expenditures related to the population and services covered by the waiver, not just those services under the waiver,** in developing their cost-effectiveness calculations. See the detailed instructions below for additional guidance.

CMS will evaluate cost-effectiveness based on all Medicaid expenditures for waiver enrollees impacted by the waiver, even those expenditures that are outside the capitation rate or do not require a PCCM referral. These services are generally referred to as "wrap-around" or "carved-out" services and may include such services as pharmacy or school-based services that may be paid on a fee-for-service (FFS) basis for the population covered by the waiver. See the detailed instructions below for additional guidance. Additional guidance is also available in the technical assistance guide for cost-effectiveness. Each State will need to work with CMS to determine whether or not services that are not explicitly under the waiver should be included in the cost-effectiveness calculations.

Because all affected Medicaid Medical Assistance program expenditures for waiver enrollees will be counted in cost-effectiveness calculations, there will essentially be no difference in the extent to which services are impacted by either a PCCM system or capitated program cost-effectiveness test. Initial waivers with both PCCM and capitated delivery systems may need to make some specific adjustments in PCCM system expenditures as noted in the **State Completion Section D.I.I Special Note for Capitated and PCCM combined initial waivers**.

State administrative costs associated with the program and population enrolled in the waiver will also be reported. Administrative costs include, but are not limited to, State expenditures such as enrollment broker contracts, contract administration, enrollee information and outreach, State utilization review and quality assurance activities, State hotline and member services costs, the cost of an Independent Assessment, External Quality Review (EQR), actuary contracts, and administrative cost allocation (salaries).

All administrative and service costs should be calculated on a per member/per month basis. States are not held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of caseload in the cost-effectiveness test. States should have total PMPM actual waiver expenditures for the two-year period equal to or less than the corresponding total PMPM projected waiver expenditures for that same period. For the purpose of on-going quarterly monitoring, the ROs will be using a two-fold test: one examining aggregate projected spending compared to the aggregate CMS-64 totals and the second examining PMPM spending compared to PMPM projections. *See the instructions for Appendix D6 for the explanation of the two calculations and detailed instructions on how to calculate and monitor each test.* **For the ultimate decision of cost-effectiveness (i.e. the decision to renew each waiver), the State will not be held accountable for caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.**

Cost-effectiveness will be calculated on a total PMPM basis, which is comprised of both service and administration costs.

CMS will track and evaluate waiver cost effectiveness using expenditure data as reported on the CMS-64 and will be measured in total computable dollars (Federal and State share). All waiver expenditures will be reported on the CMS-64.9 Waiver, CMS-64.21U Waiver, or CMS-64.10 Waiver forms on a quarterly basis. (Data from the CMS-64.21U Waiver form will be used if the State enrolls its Medicaid-expansion SCHIP population in the waiver.)

All expenditures are based on the CMS-64 Waiver forms, which are based on date of payment, not date of service. States will itemize all expenditures for the population covered under the Waiver into each of the main service categories in the CMS-64 Waiver forms. These forms have been cleared by OMB (No. 0938-0067). The *Form CMS-64.9 Waiver* for Medical Assistance payments includes the major categories of service: inpatient hospital services, physician services, dental, clinic, MCO capitation, etc. Administrative expenditures will be reported on the CMS-64.10 Waiver form

accordingly. *Note: please ensure that the State's projections for initial, conversion, and renewal waivers are projections for date of payment as well.*

States with multiple 1915(b), 1915(c), and 1115 waivers that have overlapping waiver populations will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the *CMS-64 Summary*.

All actual expenditures reported and used as the basis for a cost effectiveness projection must be verified by the RO.

The expenditures and enrollment numbers for voluntary populations (i.e., populations that can choose between joining managed care and staying in FFS) should be excluded from the waiver cost-effectiveness calculations if these individuals are not included in State's 1915(b) waiver. In general, CMS believes that voluntary populations should not be included in 1915(b) waivers. If the State wants to include voluntary populations in the waiver, then the expenditures and enrollment numbers for that population must be included in the cost-effectiveness calculations. In addition, States that elect to include voluntary populations in their waiver are required to submit a written explanation of how selection bias will be addressed in the waiver cost-effectiveness calculations. *Note: This principle does not change the historic practice of requiring States to include the experience of a voluntary MCO population in a mandatory PCCM waiver if a beneficiary can be auto-assigned to one of the delivery systems.*

States with 1932 managed care SPA programs with an overlapping 1915(b) waiver will need to work with their CMS Regional Office to ensure that expenditures are only reported once on the CMS-64 Summary.

Incentive payments will be included in the cost effectiveness test. Incentives included in capitated rates are already constrained by the Medicaid managed care regulation at 42 CFR 438.6(c) to 105% of the capitated rates based on State Plan services. If there are any incentives in FFS/PCCM, those payments must be applied under the cost-effectiveness test. For example, if PCCM providers are given incentives for reducing utilization, the incentives are limited to the savings of State Plan service costs under the waiver. This policy creates a restraint on the FFS/PCCM incentive costs. States should ensure that all incentives are reported in renewal Actual Waiver Costs in **Appendix D3**.

1915(b)(3) waiver services will be included in the cost effectiveness test. In general, States cannot spend more on 1915(b)(3) services than they would save on State Plan services.

Cost Effectiveness requirements apply to Medicaid Expansion SCHIP populations under 1905(u)(2) and (u)(3) under 1915(b) waivers. This requirement does not apply to separate stand alone SCHIP programs that are not Medicaid expansion programs or Medicaid Expansion populations not under 1915(b) waivers. Medicaid Expansion populations under 1905(u)(2) and (u)(3) should be included under 1915(b) waivers if the State is required to waive 1915(b)(1) or 1915(b)(4) in order to implement a particular

programmatic aspect of their FFS or managed care program in the Medicaid delivery system.

Comprehensive Waiver Criteria - When a person or population in a waiver receives services meeting the following criteria, the waiver would be processed under the Comprehensive Waiver Test:

- Additional waiver services are provided to waiver enrollees under 1915(b)(3) authority,
- Enhanced payments or incentives are made to contractors or providers (e.g., quality incentives paid to MCOs/PIHPs/PAHPs or providers, etc), or
- State Plan services were procured using sole source procurement (Sole source procurement means non-open, non-competitive procurement not meeting the requirements at 45 CFR 74.43). States must utilize the Comprehensive Cost Effectiveness Test to apply for and renew 1915(b) waivers that award services contracts using procurement methods meeting the criteria in 45 CFR 74.44 (e). Most competitive procurements resulting in a single contractor are not considered sole-source procurement under the 45 CFR 74.44(e) criteria. The State should verify the regulatory requirements and use the expedited test only if all expedited criteria are met.

Expedited Test – CMS is proposing a waiver-by-waiver test to expedite the processing of certain renewal waivers. States with waivers meeting requirements for the Expedited Test do not have to complete Actual Waiver Cost **Appendix D3** in the renewal and will not be subject to OMB review for that renewal waiver. States will simply submit *Schedule D* from MBES to CMS along with projections for the upcoming waiver period (**Appendices D1, D2.S, D2.A, D4, D5, and D6 and D7**). For additional guidance, please see the Cost-effectiveness Technical Assistance Manual. To be able to use the Expedited Test for a particular waiver, a State would need to:

- Submit a single 1915(b) waiver and cost-effectiveness analysis for all delivery systems with overlapping populations (overlapping populations are described further in the Technical Assistance Manual). None of the overlapping populations could meet the Comprehensive Waiver Criteria, OR
- Submit a separate 1915(b) waiver and cost-effectiveness analysis for each population. No population could receive any services under a 1915(b) waiver that meets the Comprehensive Waiver Criteria except for transportation and dental waivers as noted below.

Cost-effectiveness for waivers of only transportation services or dental pre-paid ambulatory health plans (PAHPs) are processed under the expedited test if the transportation or dental waiver alone meets the expedited criteria. In this instance, States should not consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. If enrollees in a transportation or dental waiver are also enrolled in pre-paid inpatient health plans (PIHPs), MCOs, or PCCMs under separate waivers or separate SPA authority, the costs associated with dental or transportation services should not be included in any other 1915(b) waiver cost effectiveness test.

## III. Instructions for Appendices

**Step-by-Step Instructions for Calculating Cost-Effectiveness**

**Appendix D1 – Member Months**

Document member months in the Base Year (BY)/ Retrospective Waiver Period (R1 and R2) and estimate projected member months in the upcoming period (P1 and P2) on a quarterly basis. Actual enrollment data for the retrospective waiver period must be obtained from the State's tracking system. Projected enrollment data for the upcoming period is needed for RO monitoring on a quarterly basis. States will not be held accountable for caseload changes. This data is also useful in assessing future enrollment changes in the waiver.

States must document the number of member months in the waiver for the retrospective waiver period (R1 and R2) for renewal waivers and in the base year (BY) for initial and conversion waivers.

For initial or conversion waivers, document member months from the Base Year (BY). For renewal waivers, document member months from Retrospective Waiver Period (R1 and R2). Categorize all enrollees into Medicaid Eligibility Groups (MEG). A MEG is usually determined by eligibility group, geography, or other characteristics that would appropriately reflect the services that will be provided. Please note that States will use these same MEGs to report expenditures on the CMS 64.9 Waiver, CMS 64.10 Waiver, and/or CMS 64.21U Waiver.

CMS recommends that the State analyze their capitated program's rate cell categories to support the development of the Medicaid Eligibility Group (MEG) detail within the cost-effectiveness analysis. A MEG is a reporting group collapsing rate cell categories into groups that the State anticipates will have similar inflation and utilization trends, as well as by program structure (eligibility, geography, service delivery, etc). Every MEG created will mean a separate CMS 64.9 Waiver form, etc and results in additional quarterly expenditure reports to CMS. Selecting the right number of MEGs is a very important step. *See the MEG definition above for further guidance.* States should use the 64.9 and 64.21 waiver form population categories for any renewals. *For example, Nebraska chose to divide their single waiver into four MEGs. Nebraska has Medicaid Expansion SCHIP populations in their 1915(b) waiver, which automatically means that 2 MEGs are necessary (one for TXIX and one for MCHIP). In addition, Nebraska chose to separate costs for Special Needs children's populations and AI/AN populations from all other enrollees because of the structure of their program and differential caseload trends that they anticipate. During the waiver, Nebraska will report waiver costs on two separate 64.9 Waiver forms ((Medicaid (No CSHCN or AI/AN – PIHP only), and Medicaid (CSHCN or AI/AN– MCO/PIHP/PCCM) and two separate 64.21U Waiver forms (MCHIP (No CSHCN or AI/AN– PIHP only), MCHIP (CSHCN or AI/AN – MCO/PIHP/PCCM)). In Nebraska's renewal they would have a MEG for each of the four populations).*

**Step 1.** List the Medicaid Eligibility Groups (MEGs) for the waiver. List the base year eligible member months by MEG. Please list the MEGs for the population to be enrolled in the waiver program. The number and distribution of MEGs will vary by State. For renewals, if the State used different MEGs in R1 and R2 than in P1 and P2, please create separate tables for the two waiver periods (the State will be held accountable for caseload changes between MEGs in this instance). The base year for an initial waiver should be the same as the FFS data used to create the PMPM Actual Waiver Costs. Base year eligibility adjustments such as shifts in eligibility resulting in an increase or decrease in the number of member months enrolled in the program should be noted in the Appendix and explained in the State Completion Section of the Preprint.

**Step 2.** Project by quarter, the number of member months by MEG for the population that will participate in the waiver program for the future waiver period (P1 and P2). The member months estimation should be based on the actual State eligibility data in the base year and the experience of the program in R1 and R2. List the quarterly member/eligible months projected in each MEG by quarter. States who are phasing in managed care programs or populations may choose to have quarterly estimates that are not equal (i.e., P1 Q1 reflects a different enrollment than P1 Q4).

**Step 3.** Total the member/eligible months for each quarter and year. Calculate the annual and quarterly rate of increase/decrease in member months over the projected period. Explain the rate of increase/decrease in the State Completion section.

**Appendix D2.S - Services in Waiver Cost**

Document the services included in the waiver cost-effectiveness analysis.

**Step 1.** List each State Plan service and 1915(b)(3) service under the waiver and indicate whether or not the service is:

- State Plan approved;
- A 1915(b)(3) service;
- A service that is included in a capitation rate; paid to either MCOs, PIHPs, or PAHPs, (whichever is applicable);
- A service that is not a waiver service but is impacted by the MCOs, PIHPS, or PAHPs (whichever is applicable);
- a service that is included in the PCCM FFS reimbursement.

The chart in **Appendix D2.S** should be modified to reflect each State's actual waiver program. States should indicate which services are provided under each MEG, if the benefit package varies by MEG. Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

**Step 2.** Please note any proposed changes in services on Appendix D2.S with a *. *See the Nebraska example for illustration purposes.*

**Step 3.** List the State Plan Services included in the Actual Waiver costs (only State Plan Service costs may be included in an initial waiver's Actual Waiver Costs). Please also list the 1915(b)(3) non-State Plan services proposed in the initial waiver and any 1915(b)(3) services included in the Actual Waiver costs for a conversion or renewal waiver. For an MCO/PIHP/PAHP waiver, include services under the capitated rates, as well as services provided to managed care enrollees on a fee-for-service wraparound basis (note each). For a PCCM program, include services requiring a referral, as well as services provided to waiver enrollees on a wraparound basis. Please add lines and specify as needed.

**(Column B Explanation) Services**: The list of services below is provided as *an example only. States should modify the list to include:*

-- all services available in the State's State Plan, regardless of whether they will be included or excluded under the waiver
-- subset(s) of state plan amendment services which will be carved out, if applicable; for example, list mental health separately if it will be carved out of physician and hospital services
-- services not covered by the state plan (note: only add these to the list if this is a 1915(b)(3) waiver, which uses cost savings to provide additional services)

**(Column C Explanation) State Plan Approved**: Check this column if this is a Medicaid State Plan approved service. This information is needed because only Medicaid State Plan approved services can be included in cost effectiveness. For 1915(b)(3) waivers it will also distinguish existing Medicaid versus new services available under the waiver.

**(Column D Explanation) 1915(b)(3) waiver services**: If a covered service is not a Medicaid State Plan approved service, check this column. Marking this column will distinguish new services available under the waiver versus existing Medicaid service.

**(Column E Explanation) MCO Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the MCO. If a 1915(b)(3) service in an MCO is capitated, please mark this column.

**(Column F Explanation) Fee-for-Service Reimbursement impacted by MCO**: Check this column if the service is not the responsibility of the MCO, but the MCO or its contracted providers can affect the utilization, referral or spending for that service. *For example, if the MCO is responsible for physician services but the State pays for pharmacy on a FFS basis, the MCO will impact pharmacy use because access to drugs requires a physician prescription*. Do not mark services NOT impacted by the MCO and not included in the cost-effectiveness analysis. *For example, a State would not include Optometrist screening exams in states where vision services are not capitated, a PCP referral is not required for payment, and PCP do not refer or affect patient access to vision screening examinations.*

**(Column G Explanation) PCCM Fee-for-Service Reimbursement:** Check this column if this service will be included in the waiver and will require a referral/prior authorization or if the service is not covered under the waiver and does not require a referral/prior authorization, but is impacted by it. For example, a goal of most primary care case management programs is that emergency services would be reduced. For example, if the State pays for pharmacy on a FFS basis, but does not require a referral from the primary care case manager to process those claims, the primary care case manager will still impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the waiver. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

**(Column H Explanation) PIHP Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the PIHP. If a 1915(b)(3) service is capitated in a PIHP, please mark this column.

**(Column I Explanation) Fee-for-Service Reimbursement impacted by PIHP**: Check this column if the service is not the responsibility of the PIHP, but is impacted by it. For example, if the PIHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PIHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PIHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance.*

**(Column J Explanation) PAHP Capitated Reimbursement**: Check this column if this service will be included in the capitation or other reimbursement to the PAHP. If a 1915(b)(3) service is capitated in a PAHP, please mark this column. *Note: the Nebraska example did not include a PAHP and so did not include this column.*

**(Column K Explanation) Fee-for-Service Reimbursement impacted by PAHP**: Check this column if the service is not the responsibility of the PAHP, but is impacted by it. For example, if the PAHP is responsible for physician services but the State pays for pharmacy on a FFS basis, the PAHP will impact pharmacy use because access to drugs requires a physician prescription. Do not include services NOT impacted by the PAHP. *Please see the **Inclusion of Services in Cost-Effectiveness Test** chart below for guidance. Note: the Nebraska example does not include a PAHP delivery system and so did not include this column.*

Note: Columns C and D are mutually exclusive. Columns E and F are mutually exclusive for the MCO program. Columns H and I are mutually exclusive for the PIHP program. Columns J and K are mutually exclusive for the PAHP program. Each service should have a mark in columns C or D. If the State has more than one MEG, Appendix D2 should reflect what services are included in each MEG.

**Chart: Inclusion of Services in Cost-Effectiveness Test**

Note: All references to the single CMS 64.9 Waiver form refer to a 1915(b) waiver that does not include any SCHIP Medicaid expansion populations. If a 1915(b) includes an SCHIP

Medicaid expansion population, the State would also complete a CMS 64.21U Waiver form for the applicable SCHIP Medicaid expansion population. In addition, the State can always choose to divide its data into MEGs for additional reporting categories. Services included in other 1915(b) waivers should be excluded and not counted under two separate 1915(b) cost-effectiveness tests. Services in 1915(c) waivers should only be included for concurrent 1915(b)/1915(c) waivers. Services for 1115 Demonstration waivers should only be included if the 1915(b) population is being used as an impacted population in the 1115 Demonstration. *See the Technical Assistance Manual for additional information.*

| Example | Type of Delivery System | Services Under 1915(b) waiver | Services included in Cost Effectiveness Test | Services excluded from Cost Effectiveness Test |
|---|---|---|---|---|
| Medicaid beneficiary is enrolled only in 1915(b) for transportation | PAHP | Transportation only | Transportation | All other Medicaid services |
| Medicaid beneficiary is enrolled only in 1915(b) for dental | PAHP | Dental only | Dental | All other Medicaid services |
| Medicaid beneficiary is enrolled only in 1915(b) for mental health – remaining services are FFS or under 1932 SPA *(examples: rural Nebraska and Iowa)* | PIHP | Mental Health and Substance Abuse are under waiver. Pharmacy, rehabilitation services, and inpatient psychiatric services for individuals under age 21 are fee-for-service. | All Mental Health, Substance Abuse, Pharmacy, Inpatient psychiatric services for individuals under age 21, and Rehabilitation services for waiver enrollees are reported on single *CMS-64.9 Waiver form* for the 1915(b) waiver. | All other Medicaid services |
| Medicaid beneficiary is enrolled in one 1915(b) waiver for mental health and MCO services *(examples: urban Nebraska special needs children)* | PIHP and MCO | All services | All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form* | None. |
| Medicaid beneficiary is | PIHP and MCO | All services except pharmacy are in | The State divides all services for waiver | None. |

| Example | Type of Delivery System | Services Under 1915(b) waiver | Services included in Cost Effectiveness Test | Services excluded from Cost Effectiveness Test |
|---|---|---|---|---|
| enrolled in 1915(b) for mental health and separate 1915(b) for MCO | | one waiver or the other | enrollees into two *CMS-64.9 Waiver forms*: one for the mental health 1915(b) and the other for the MCO 1915(b). | |
| Medicaid beneficiary is enrolled in a single1915(b) for mental health and PCCM *(examples: urban Nebraska special needs children)* | PIHP and PCCM | All services except school-based services | All services including school-based services for waiver enrollees are reported on a *CMS-64.9 Waiver form* | None. |
| Medicaid beneficiary is enrolled in 1915(b) PCCM or MCO | PCCM and/or MCO | All services | All services for waiver enrollees are reported on a single *CMS-64.9 Waiver form* | None. |

**Appendix D2.A Administrative Costs in the Waiver**
Document the administrative costs included in the Actual Waiver Cost.

**Step 1.** Using *CMS-64.10 Waiver Form* line items numbers and titles, document the State's administrative costs in the waiver. **Do not include MCO/PIHP/PAHP/PCCM entity administration costs.** For initial waivers, this will include only fee-for-service costs such as MMIS and SURS costs. For renewal waivers and conversion waivers, the administrative costs will include managed care costs such as enrollment brokers, External Quality Review Organizations, and Independent Assessments. Add lines as necessary to distinguish between multiple contracts on a single line in the CMS-64.10. *Note: PCCM case management fees are not considered State Administrative costs because CMS matches those payments at the FMAP rate and states claim those costs on the CMS-64.9 Waiver form. Services claimed at the FMAP rate should be reported on **Appendix D2.S** and not reported on **Appendix D2.A**.*

**Step 2.** The State should allocate administrative costs between the Fee-for-service and managed care program depending upon the program structure. For example, for an MCO program, the State might allocate the administrative costs in the Administrative Cost Allocation Plan to the MCO program based upon the number of MCO enrollees as a

percentage of total Medicaid enrollees. For a mental health carve out enrolling most Medicaid beneficiaries in the State, allocate costs based upon the mental health program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. Explain the cost allocation process in the preprint.

**Appendix D3 – Actual Waiver Cost**

Document Base Year and Retrospective Waiver Period expenditures (actual expenditures in the BY for initial/conversion waivers and R1 and R2 in renewal waivers). States that are eligible to use the expedited process for certain waivers need not complete Appendix D3; instead, attach the most recent waiver Schedule D. For all other submissions, States should complete **Appendix D3**.

The State must document the total expenditures for the services impacted by the waiver as noted in **Appendix D2.S**, not just for the services under the waiver. For an Initial Waiver or Conversion Waiver, the State must document the expenditures used in the BY PMPM. **All expenditures in the BY will be verified by the RO.** For a Renewal Waiver, the State must document the actual expenditures in the retrospective two-year period (R1 and R2) separating administration, 1915(b)(3), FFS incentives, capitated, and fee-for-service State Plan expenditures as noted. **Actual expenditures will be verified by the RO on a quarterly basis by comparing projections to actual expenditures and other routine audit functions.**

The actual expenditures used in the cost-effectiveness calculations should include all Medicaid program expenditures related to the population covered by the waiver, not just those services directly included in the waiver. If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64. Incentives to capitated entities are reflected in **Column D of Appendix D3** of the spreadsheets. Fee-for-service incentives, such as incentives to PCCM providers, are noted separately in **Column G of Appendix D3**. 1915(b)(3) services in the initial waiver will always be zero in **Column H of Appendix D3** of the initial waiver because 1915(b)(3) services are a result of savings under the waiver and cannot exist prior to the waiver.

Actual expenditures are based on the CMS-64 Waiver forms, which are based on date of payment not date of service.

States must separately document actual Medical Assistance service expenditures and actual State administrative costs related to those services. Actual case management fees paid to providers in a PCCM program should be included as service expenditures.

Since a State may be in the process of developing a Renewal Waiver during the second year of the waiver (R2) period (to avoid an extension), the State use only data from the Schedule D and document the number of months of data used on Appendix D7.

Appendix D7 will recalculate the formulas based upon the amount of data available to the State. The State should not project any actual expenditures that are not yet available for R2.

Should a State request and be granted one or more 90-day temporary extension(s) for submitting a Renewal Waiver, the following process applies depending on the length of the extension:

- For three or fewer 90-day temporary extensions (a period of less than one year after the expiration of the waiver), the State must demonstrate cost-effectiveness over the original two-year period included in the waiver. In other words, if a waiver considered years CY 2003 and CY 2004 as P1 and P2, respectively, and 2 three-month temporary extensions were obtained, the State would still be required to demonstrate cost-effectiveness for calendar year 2003 and 2004 by comparing actual expenditures (R1 and R2) to the projected expenditures (P1 and P2) for these two years in aggregate. In this scenario, actual expenditures for the entire R2 period may be available to support the Renewal Waiver calculations.
- For four or more temporary extensions (a period of one year or more after the expiration of the waiver), the State must demonstrate cost-effectiveness for the original two-year period included in the waiver as previously described and in addition demonstrate cost-effectiveness for the one-year extension period (to the extent data is available – in this case CY2005). In this scenario, actual expenditures for the entire R2 period will be available to support the Renewal Waiver calculations, but the extension year may require projecting actual expenditures. The State's extension year will be compared to the expenditure projections as if P2 were 24 months rather than 12 months.

| Number of Extensions | Demonstration of Cost-Effectiveness | Example |
|---|---|---|
| 3 or fewer 90-day temporary extensions | Demonstrate cost-effectiveness for the original two-year period | Waiver CY2003 and CY2004<br>2 Extensions through 7/1/2005<br><br>State CE covers only CY2003 and CY2004 |
| 4 or more temporary 90-day extensions | Demonstrate cost-effectiveness for the original two-year period and for each additional one-year extension period | Waiver CY2003 and CY2004<br>4 Extensions through CY2005<br><br>State CE covers CY2003, CY2004, and CY2005 |

Fee-for-service Institutional UPL Expenditures to include and not include in the cost-effectiveness analyses.

- **Transition amounts should be excluded** from the Cost-Effectiveness test. A transition amount is what the State spent over 100% of the institutional fee-for-service UPL (i.e., the "excess"). The State should isolate the excess amounts to

remain in fee-for-service outside of the waiver and include only the amount under 100% of the FFS UPL in the Cost-effectiveness analysis.

- **Supplemental payments at or below 100% of the UPL should be included** in the cost-effectiveness analysis. States that are not transition States may in fact make supplemental payments below or up to the 100% UPL and that money should be included in the cost-effectiveness. The entire amount of the supplemental payment at or below the UPL should be in the 1915(b) analysis.

**States should contact their RO for additional State-specific guidance on the inclusion and exclusion of Fee-for-service Institutional UPL payments.**

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.** The renewal will list the MEGS twice – once for R1 and once for R2. *See the example spreadsheets.*

**Step 2.** List the BY eligible member months (R1 and R2 member months, if a renewal). *See the example spreadsheets.*

**Step 3.** List the base year (R1 and R2 if a renewal) aggregate costs by MEG. Actual cost and eligibility data are required for BY (R1 and R2) PMPM computations. Aggregate Capitated Costs are in Column D. Aggregate FFS costs are in Column E. Add D+E to obtain the State Plan total aggregate costs in Column F. List FFS incentives in Column G. In a renewal or conversion waiver, list 1915(b)(3) aggregate costs in Column H. List Administrative costs in Column I. For an initial waiver, these PMPM costs are derived from the State's MMIS database or as noted from the explanation in the State Completion section under **Section D.I.H.a** Comprehensive Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D and with additional ad hoc reporting for 1915(b)(3) services and FFS incentive payments. The State must track FFS incentive and 1915(b)(3) payments separately (those costs will not be separately identified on Schedule D). The State must document that State Plan service aggregate costs amounts were reduced by the amount of FFS incentives and 1915(b)(3) costs spent by the State. To calculate the PMPM by MEG for 1915(b)(3) services, the State should divide the cost of 1915(b)(3) service costs by MEG for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for FFS incentives, the State should divide the cost of FFS incentives for R2 and divide by the R2 member months for each MEG. To calculate the PMPM by MEG for State Plan Services, the State should divide the cost of State Plan Services from Schedule D (minus FFS incentives and 1915(b)(3) service costs) for R2 and divide by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts. *Note: the Total Cost per Waiver Year for R1 for renewals should match the Schedule D submitted.*

**Step 4. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.**

**Step 5.** The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training conducted by CMS in April 2003 and States should pay particular attention to this detail.***

**Step 6.** Total the base year capitated costs and fee-for-service costs to derive the total base year costs for services. Add all costs (F, G, H, and I) to obtain total waiver aggregate costs.

**Step 7.** Divide the base year (BY) costs by the annual BY (divide the R1 costs by the R1 MM or the R2 costs by the R2 MM, if a renewal) member months (MM) to get PMPM base year (R1 or R2) costs**.** In this instance, the State calculates the overall PMPM for BY (the overall PMPM for R1 or the overall PMPM for R2 in a renewal). The State will divide the costs of the program by the caseload for the same year from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each year of the waiver (R1 and R2). In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

| Initial/Conversion | Renewal R1 | Renewal R2 |
|---|---|---|
| BY Costs<br>BY MM | R1 Costs<br>R1 MM | R2 Costs<br>R2 MM |
| Overall PMPM for BY | Overall PMPM for R1 | Overall PMPM for R2 |

**Appendix D4 – Adjustments in the Projection**

Document adjustments made to the BY or R1 and R2 to calculate the P1 and P2. The State will mark the adjustments made and document where in Appendix D5 the adjustment can be found. All adjustments are then explained in the State Completion portion of the Preprint.

**Waiver Cost Projection Adjustments:** On **Appendix D4**, check all adjustments that the State applied to the R1/R2 or BY data. In Column D, note the location of each adjustment in **Appendix D5**. Note: only the adjustments listed may be made. If the State has made another adjustment, the State should obtain CMS approval prior to its use. Complete the attached preprint explanation pages and include attachments as requested. ***Note:*** *(Initial Waiver only) Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- some adjustments to the Waiver Cost Projection in an initial waiver must be made due to a policy decision in the capitated program. Those adjustments are permitted only to the capitated programs and need an offsetting adjustment to the PCCM Waiver Cost Projections in order to make the PCCM costs comparable to the Actual Waiver Costs. Please see the State Completion Section of the initial waiver for further instructions if the State has a combined capitated and PCCM cost-effectiveness analysis.*

**Appendix D5 – Waiver Cost Projection**

Each time a waiver is renewed, a State must develop a two-year projection of expenditures. States must calculate projected waiver expenditures (P1 and P2) for the upcoming period. Projected waiver expenditures for P1 and P2 should be created using the State's actual historical expenditures (e.g., BY data for an Initial or Conversion Waiver, or R2 data using R1 & R2 experience to develop trends for a Renewal Waiver) for the population covered under the waiver and adjusted for changes in trend (including utilization and cost increases) and other adjustments acceptable to CMS. For example, in an Initial or Conversion Waiver, a State should use its actual BY data to project its P1 and P2 expenditures. In a Renewal Waiver, a State should use its actual experience in R1 and R2 to project trends for its P1 and P2 expenditures from the endpoint of the previous waiver of R2. As a result, in each subsequent Renewal Waiver, the State will use an updated set of base data from R1 and R2 (to "rebase") for use in projecting the Renewal Waiver's P1 and P2.

Projected waiver expenditures must include all Medicaid expenditures for the population included in the waiver, not just those services directly included in the waiver, calculated on a PMPM basis and including administrative expenses. (For example, a State must include services that are outside of the capitated or PCCM program.) If the State has multiple waivers with overlapping populations, the State should work with the CMS Regional Office to determine which expenditures should be allocated to which waiver in order to ensure that expenditures are only reported once on the CMS-64.

In projecting expenditures for the population covered by the waiver, States must use trends that are reflective of the regulation requirements for capitated rates and fee-for-service history for fee-for-service rates. The State must document and explain the creation of its trends in the State Completion Section of the Preprint. CMS recommends that a State use at least three years of Medicaid historical data to develop trends. States must use the State historical trends for the time periods where actual State experience is available. States must use the prescribed methods (see the State Completion Section) for inflating FFS incentives (no greater than the State Plan trend rate), 1915(b)(3) services (the lower of State Plan service and actual 1915(b)(3) trend rates), and administration (historic Medicaid administration trend rates unless the State is using sole source procurement to procure State Plan services)

States need to make adjustments to the historical data (BY for initial/conversion and R2 for renewals) used in projecting the future P1 and P2 PMPMs to reflect prospective periods. For Renewals, these adjustments represent the impact on the cost of the State's Medicaid program from such things as: State Plan service trend, State Plan programmatic/policy/pricing changes, administrative cost adjustments, 1915(b)(3) service trends, incentives (not in the capitated payment) adjustments, and other. Since States are required to consider the effect of all Medicaid costs for the waiver population, States

should consider adjustments that might impact costs for services not directly covered under the waiver (i.e., global changes to the Medicaid program).

1915(b)(3) services must be paid out of savings in the future years (P1 and P2) of the waiver. Under 1915(b)(3) authority, states can offer additional benefits using savings from providing State Plan services more efficiently. The following principles and requirements will be used to evaluate the cost-effectiveness of waiver requests that include 1915(b)(3) services. The principles are intended to highlight concepts and policy goals (i.e., **what** the policy guidance is intended to accomplish). The requirements are intended to outline operational details (i.e., **how** the policy goals will be pursued).

**2) Aggregate spending**

- *General principle*—Under a 1915(b) waiver, combined spending on State Plan and 1915(b)(3) services cannot exceed what would have occurred without the waiver. In other words, States cannot spend more on 1915(b)(3) services than they save on State Plan services under the waiver.
- ➢ *Requirement*—Combined spending on State Plan and 1915(b)(3) services cannot exceed projected spending during any given waiver period.

**3) Base-year spending (R2 for renewals) (for waiver projections)**

- *General principle one*—Spending for 1915(b)(3) services should not exceed the cost of providing these services.
- *General principle two*—Spending for 1915(b)(3) services should not exceed the "budget" for these services, as determined in a state's waiver application.
- ➢ *Requirement (for initial waiver applications)*—The base year amount for 1915(b)(3) services under a new waiver application is limited to the lower of:
  a. Expected costs for the 1915(b)(3) services or
  b. Projected savings on State Plan services
- ➢ *Requirement (for Renewals and Conversion Renewals)*—The base year (R2 for renewals) amount for projecting spending on 1915(b)(3) services under a waiver renewal is limited to the lower of:
  a. Actual costs for 1915(b)(3) services under the current waiver or
  b. Projected costs for 1915(b)(3) services under the current waiver (P2 in the previous submittal)

**4) Growth in spending (price increases and use of services, but not changes in enrollment)**

- *General principle one*—Growth in spending on 1915(b)(3) services cannot exceed growth in spending for State Plan services under the waiver. (This ensures that savings on State Plan services for both initial waiver and renewal periods finance spending for 1915(b)(3) services.)
- *General principle two*—Growth in spending on 1915(b)(3) services cannot exceed historical growth in spending for these services. (This ensures that growth in spending on waiver services is reasonable for the particular services.)

- *Requirement*—Growth in spending for 1915(b)(3) services is limited to the lower of:
  a. The overall rate of trend for State Plan services, or
  b. State historical trend for 1915(b)(3) services

**5) Covered services**

- *General principle*—If the State wants to expand 1915(b)(3) services, the State must realize additional savings on State Plan services to pay for the new services.
- *Requirement*—Before increasing its budget for 1915(b)(3) waiver services, the State must submit an application to CMS to modify its waiver (or document the modification in its renewal submittal). This application must show both:
  a. How additional savings on State Plan services will be realized, and
  b. That the savings will be sufficient to finance expanded services under the waiver
- *Special case*—A State also could be required to cut back (b)(3) services because of increased use of State Plan services.

**5) Payments**

- *Requirement*—As a condition of the waiver, capitated 1915(b)(3) payments must be calculated in an actuarially sound manner.

States must calculate a separate capitation payment for 1915(b)(3) services using actuarial principles and the same guiding principles as the regulation at 42 CFR 438.6(c) -with the exceptions that the 1915(b)(3) rates are based solely on 1915(b)(3) services approved by CMS in the waiver and the administration of those services. The actual payment of the 1915(b)(3) capitated payment can be simultaneous with the payment of the State Plan capitated payment and appear as a single capitation payment. However, the State must be able to track and account for 1915(b)(3) expenditures separately from State Plan services.

1915(b)(3) services versus 42 CFR 438.6(e) services. Under a 1915(b) waiver, 1915(b)(3) services are services mandated by the State and paid for out of State waiver savings. 42 CFR 438.6(e) services are services provided voluntarily by a capitated entity out of its capitated savings. A State cannot mandate the provision of 42 CFR 438.6(e) services. In order to provide a service to its Medicaid beneficiaries, the State must have authority under its State Plan or through a waiver such as the 1915(b)(3) waiver. 1915(c) and 1115 Demonstration waivers also have authority for the provision of services outside of the Medicaid State Plan. CMS will match managed care expenditures for services under the State Plan or approved through an approved waiver. The State cannot mandate the provision of services outside of its State Plan or a waiver.

Initial waivers must estimate the amount of savings from fee-for-service that will be expended upon 1915(b)(3) services in the initial waiver. The State must document that the savings in state plan services, such as reductions of utilization in hospital and

physician services, are enough to pay for the projected 1915(b)(3) services. If the State contends that there is additional state plan savings generated from the 1915(b)(3) services those can only be documented after the State has documented that state plan-generated savings are enough to pay for the 1915(b)(3) Costs. Trend for 1915(b)(3) services in the initial waiver can be no greater than State Plan service trend (because there is no historic 1915(b)(3) service trend rate) as noted in the adjustments section.

The State must separately document Medical Assistance service expenditures and State administrative costs related to those services. Case management fees paid to providers in a PCCM program should be included as Medical Assistance service expenditures.

A State may make changes to their Medicaid and/or Medicaid waiver programs (e.g., changes to covered services or eligibility groups) during the period of time covered by an existing waiver. When the State makes these changes and there is a cost impact, CMS will require States to submit amendments which will modify P1 and P2 of the existing waiver calculations. By amending the existing P1 and P2 the State will ensure that when the State does its subsequent Renewal Waiver the R1 and R2 actual expenditures do not exceed the previous waiver's P1 and P2 expenditures solely as a result of the change to the Medicaid and/or Medicaid waiver program.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

**Step 2.** List the BY eligible member months (R2 if a renewal). *See the example spreadsheets.*

**Step 3.** List the weighted average PMPM calculated in **Appendix D3** for Initial, Conversion or Comprehensive Renewal waivers.

Expedited Renewal waivers will calculate the PMPM service amount by MEG from the most recent Schedule D. To calculate the PMPM by MEG, the State should divide the cost from Schedule D for R2 and by the R2 member months for each MEG. The State should calculate the PMPM administration amount by dividing the administration cost from Schedule D by the R2 member months. The State must submit the Schedule D used to calculate the PMPM amounts.

**Step 4.** In **Appendix D5**, list the program adjustments percentages and the monetary size of the adjustment by MEG as applicable for State Plan services. The State may then combine all adjustment factors which affect a given MEG, and apply the adjustments accordingly. The derivation of a combined adjustment factor must be explained and documented.

Note adjustments in different formats as necessary. *See the Nebraska example spreadsheet as an example only. Some adjustments may be additive and others may be multiplicative. Please use the appropriate formula for the State's method.*

**Step 5.** Compute the PMPM projection by MEG by adding the service, incentive, administration, and 1915(b)(3) costs and the effect of all adjustments. These amounts need to be reflected in the State's next waiver renewal. These amounts represent the final PMPM amounts that will be applied to actual enrollment in measuring cost effectiveness. States will not be held accountable for caseload changes among MEGs when submitting their next waiver renewal cost-effectiveness calculations. In the subsequent renewal, the State should have PMPM Actual Waiver costs for each MEG for the 2-year period equal to or less than these Projected PMPM Waiver Costs for each MEG.

**Appendix D6 – RO Targets**

For the purpose of on-going quarterly monitoring in the future period, the State must document total cost and PMPM cost projections for RO use. The ROs will be using a two-fold test: one that monitors for overall growth in waiver costs on the CMS-64 forms and another that monitors for PMPM waiver cost-effectiveness. The State projections for RO use in both tests are in Appendix D6.

The first test projects quarterly aggregate expenditures by MEG for RO use in monitoring CMS 64.9 Waiver, CMS 64.21U Waiver, and CMS 64.10 Waiver expenditures during the upcoming waiver period. On a quarterly basis, CMS will compare aggregate expenditures reported by the State on CMS-64 Waiver forms to the State's projected expenditures (P1 and P2) included in the State's cost-effectiveness calculations as a part of the quarterly CMS-64 certification process. As part of the waiver submission, the State must calculate and document the projected quarterly aggregate Medical Assistance services and State administrative expenditures for the upcoming period. This projection is for the population covered under the waiver and will assist RO financial staff in monitoring the total waiver spending on an on-going basis.

The second test projects quarterly PMPM expenditures by MEG for RO use in monitoring waiver cost-effectiveness in the future waiver period. Because states are required to demonstrate cost-effectiveness in the historical two-year period of each Renewal Waiver, CMS intends to monitor State expenditures on an ongoing basis using the State's CMS-64 Waiver submissions. CMS will determine if the State's quarterly CMS-64 Waiver submissions support the State's ability to demonstrate cost-effectiveness when the State performs its Renewal Waiver calculations. For the second test, States are not held accountable for caseload increases. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State must submit member month data corresponding to the quarterly submission of the CMS-64 on an on-going basis. The State should ensure that the member month data submitted on an on-going basis is comparable to the member month data used to prepare the P1 and P2 member month projections. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months**.

**Step 2.** List the P1 and P2 projected member months by quarter for the future period.

**Step 3.** List the P1 and P2 MEG PMPM cost projections from **Appendix D5**. As part of the waiver submission, the State must calculate a services only PMPM for each MEG (by subtracting out administrative costs by MEG) for each waiver year. The State will calculate the weighted average PMPM with Casemix for P1 and P2 (respectively).

| Renewal P1 | Renewal P2 |
|---|---|
| $\frac{\text{P1 PMPM Costs x P1 MM}}{\text{P1 MM}}$ | $\frac{\text{P2 PMPM Costs x P2 MM}}{\text{P2 MM}}$ |
| Casemix for P1 | Casemix for P2 |

The State is calculating the PMPM with Casemix for P1 and P2 so that the Region can compare the projected PMPMs to the actual PMPMs for administration (the State is calculating all of the PMPMs but only the administration PMPM will be used in Appendix D6). Administration is an area of risk for States in a 1915(b) waiver. If a State does not enroll enough persons into the program to offset high fixed administration costs, the State is at risk for not being cost-effective over the two year period. The Region will use this particular weighted PMPM to monitor State enrollment levels to ensure that high administrative costs are more than offset on an on-going basis.

**Step 4.** Multiply the quarterly member month projections by the P1 and P2 PMPM projections to obtain quarterly waiver aggregate targets for the waiver. *See the example spreadsheets.*

For the first aggregate spending test, the State will use the MEG PMPM from Appendix D5 multiplied by the projected member months to obtain the aggregate spending. The MEG PMPM from Appendix D5 is the number that States will be held accountable to in their waiver renewal. However, States will not be held accountable to the projected member months in their waiver renewal. For this reason, a second test modifying the demographics to reflect actual caseload is necessary.

| | | | **Q1 Quarterly Projected Costs** | | |
|---|---|---|---|---|---|
| **Medicaid Eligibility Group (MEG)** | **Total PMPM Admini-stration Cost Projection** | **Total PMPM Projected Service Costs** | **Member Months Projections** | **64.9W /64.21U W Service Costs include incentives** | **64.10 Waiver Admini-stration Costs** |
| MCHIP - MCO/PCCM/ PIHP (3 co.) | $ 10.00 | $ 192.90 | 81 | $ 15,624.75 | $ 810.39 |

| | | | | | |
|---|---|---|---|---|---|
| MCHIP - PIHP statewide | $ 0.86 | $ 21.20 | 28,821 | $ 611,004.39 | $ 24,866.56 |
| Title XIX MCO/PCCM/ PIHP (3 co) | $ 47.33 | $ 954.89 | 15,981 | $ 15,260,090.40 | $ 756,396.07 |
| Title XIX - PIHP statewide | $ 2.37 | $ 48.20 | 444,217 | $ 21,409,496.79 | $ 1,051,238.55 |
| **Total** | | | **489,100** | **$ 37,296,216.33** | **$ 1,833,311.56** |
| **Weighted Average PMPM Casemix for P1 (P1 MMs)** | **$ 3.77** | | | | |

**Step 5.** Create a separate page that documents by quarter Form 64.9 Waiver, Form 64.21U Waiver, and Form 64.10 Waiver costs separately for ease of RO CMS-64 monitoring. *See the example spreadsheets.*

Example:

Projected Year 1 - July 1, 2002 - June 30, 2003

| Waiver Form | Medicaid Eligibility Group (MEG) | Q1 Quarterly Projected Costs Start 7/1/2002 |
|---|---|---|
| **64.21U Waiver Form** | MCHIP - MCO/PCCM/PIHP (3 co) | $ 15,624.75 |
| **64.21U Waiver Form** | MCHIP - PIHP statewide | $ 611,004.39 |
| **64.9 Waiver Form** | Title XIX - MCO/PCCM/PIHP (3 co) | $ 15,260,090.40 |
| **64.9 Waiver Form** | Title XIX - PIHP statewide | $ 21,409,496.79 |
| **64.10 Waiver Form** | All MEGS | $ 1,833,311.56 |

**Step 6.** Create a separate page that documents by quarter PMPM MEG costs separately for each of RO monitoring. Please include space for RO staff to list actual member months and aggregate totals by quarter. Please include formulas for RO staff to calculate actual PMPMs by quarter for comparison to projections. *See the example spreadsheets.*

For the second test, the State will carry forward the P1 (and P2 respectively) MEG PMPM services costs and the weighted average PMPM administration costs Casemix for P1 (and P2 respectively).

Divide the actual aggregate costs by the actual aggregate member months (MM) to get PMPM actual costs**.** The State will divide the costs of the program by the caseload for the same quarter from which the State calculated the cost data. This calculation allows CMS to determine the PMPM costs with the changes in the program's caseload at the new distribution level between MEGs for each quarter of the waiver. In short, this calculation allows CMS to look at per person expenditures accounting for actual changes in the demographics of the waiver.

| On-going Actual P1 Q1 | On-going Actual P2 Q5 |
|---|---|
| P1 Q1 Actual Costs<br>P1 Q1 Actual MM | P2 Q5 Actual Costs<br>P2 Q5 Actual MM |
| Casemix for P1 Q1 actual | Casemix for P2 Q5 actual |

On an on-going basis, the State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms. The RO analyst will enter the member month and CMS-64 form totals into the worksheet, which will calculate the actual MEG PMPM costs. The RO will compare the applicable projected PMPM for services and administration to the actual PMPM for each waiver quarter. If it appears that the State's CMS-64 Waiver PMPM expenditures adjusted for actual Casemix exceeds the State's projected PMPM expenditures, CMS will work with the State to determine the reasons and to take potential corrective actions.

Example

| **Waiver Form** | **Medicaid Eligibility Group (MEG)** | **State Completion Section - For Waiver Submission** | **RO Completion Section - For ongoing monitoring** | | |
|---|---|---|---|---|---|
| | | | **Q1 Quarterly Actual Costs** | | |
| | | **P1 Projected PMPM From Column I (services) From Column G (Administration)** | **Member Months Actuals Start 7/1/2002** | **Actual Aggregate Waiver Form Costs** | **Actual PMPM Costs** |
| **64.21U Waiver Form** | MCHIP - MCO/PCCM /PIHP (3 co.) | **$ 192.90** | | | #DIV/0! |
| **64.21U Waiver Form** | MCHIP - PIHP statewide | **$ 21.20** | | | #DIV/0! |
| **64.9 Waiver Form** | Title XIX - MCO/PCCM /PIHP (3 co) | **$ 954.89** | | | #DIV/0! |
| **64.9 Waiver Form** | Title XIX - PIHP | **$ 48.20** | | | #DIV/0! |

| | | | | | |
|---|---|---|---|---|---|
| | statewide | | | | |
| **64.10 Waiver Form** | All MEGS | **$ 3.77** | | | #DIV/0! |

**Appendix D7 - Summary**

Document the State's overall cost-effectiveness analysis by waiver year.

In a renewal analysis, the State must clearly demonstrate that the PMPM actual waiver expenditures did not exceed the projected PMPM waiver expenditures for the population covered by the waiver. *For example, suppose a State's Initial Waiver (ST 01) considered years 2003 and 2004 to be P1 and P2 respectively. In the subsequent Renewal Waiver (ST 01.R01), the State's R1 and R2 will also be years 2003 and 2004, respectively. The State must demonstrate that in total the actual expenditures in the current Renewal Waiver's R1 and R2 (2003 and 2004) did not exceed the total projected expenditures in the Initial Waiver's P1 and P2 (2003 and 2004). Taking the example above, a State would use the actual expenditures from 2003 and 2004 as the basis for projecting expenditures for the renewal waiver period 2005-2006 (P1 and P2 respectively). In the second Renewal Waiver (ST 01.R02), the actual expenditures in the renewal period for 2005-2006 (R1 and R2) must be less than the expenditures for 2005-2006 (P1 and P2) projected in the previous renewal (ST 01.R01). For each subsequent renewal, the State will compare actual expenditures in R1 and R2 to the projected P1 and P2 values from the previously submitted Renewal Waiver.*

Cost-effectiveness will be determined based on the sum of Medical Assistance service expenditures and State administrative costs on a PMPM for the two-year period. In this instance, the weighted PMPM for both the projection and the actual cost is based on the Casemix for actual enrollment in R1 and R2. In this way, the State is not held accountable for any caseload changes between Medicaid Eligibility Groups nor for overall changes in the magnitude of the State's caseload.

**Step 1.** List the MEGs for the waiver. These MEGs must be identical to the MEGs used in **Appendix D1 Member Months.**

**Step 2.** List the BY (R1 and R2 if a renewal), P1 and P2 annual projected member months.

**Step 3.** List the BY (R1 and R2 if a renewal), P1 and P2 PMPM projections from **Appendix D5**.

List and calculate the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the PMPM for that year's demographics and for the previous year's demographics so that CMS can compare the PMPM for the enrolled caseload to the PMPM holding the caseload's demographics

constant. In short, the new PMPM times the old MM (new dollars times old weights = Casemix effect for old MM) is the Casemix for the old MM.

Initial or Conversion Waiver

| Year | Calculation | Where Already Calculated | Formula |
|---|---|---|---|
| BY | BY Overall PMPM for BY (BY MMs) | Appendix D3 | BY Aggregate Costs / BY MM |
| P1 | P1 Weighted Average PMPM Casemix for BY (BY MMs) | | P1 PMPM x BY MM / BY MM |
| | P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | Appendix D6 | P1 PMPM x P1 MM / P1 MM |
| P2 | P2 Weighted Average PMPM Casemix for P1 (P1 MMs) | | P2 PMPM x P1 MM / P1 MM |
| | P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | Appendix D6 | P2 PMPM x P2 MM / P2 MM |
| | P2 Weighted Average PMPM Casemix for BY (BY MMs) | | P2 PMPM x BY MM / BY MM |
| | P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | Appendix D6 | P2 PMPM x P2 MM / P2 MM |

Renewal Waiver

| Year | Calculation | Where Already Calculated | Formula |
|---|---|---|---|
| R1 | R1 Overall PMPM for R1 (R1 MMs) | Appendix D3 | R1 Aggregate Costs / R1 MM |
| R2 | R2 Weighted Average PMPM Casemix for R1 (R1 MMs) | | R2 PMPM x R1 MM / R1 MM |
| | R2 Overall PMPM for R2 (R2 MMs) | Appendix D3 | R2 Aggregate Costs / R2 MM |
| P1 | P1 Weighted Average PMPM Casemix for R2 (R2 MMs) | | P1 PMPM x R2 MM / R2 MM |
| | P1 Weighted Average PMPM Casemix for P1 (P1 MMs) | Appendix D6 | P1 PMPM x P1 MM / P1 MM |
| P2 | P2 Weighted Average PMPM Casemix for P1 (P1 MMs) | | P2 PMPM x P1 MM / P1 MM |
| | P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | Appendix D6 | P2 PMPM x P2 MM / P2 MM |
| | P2 Weighted Average PMPM Casemix for R1 (R1 MMs) | | P2 PMPM x R1 MM / R1 MM |
| | P2 Weighted Average PMPM Casemix for P2 (P2 MMs) | Appendix D6 | P2 PMPM x P2 MM / P2 MM |

**Step 4.** Calculate a total cost per waiver year. Multiply BY MM by BY PMPM. (Renewal Waiver, multiply R1 MM by R1 PMPM and multiply R2 MM by R2 PMPM) Multiply P1 MM by P1 PMPM. Multiply P2 MM by P2 PMPM. *Note: the Total Cost*

*per Waiver Year for R1 for renewals should match the Schedule D submitted. A portion of R2 may be projected in order to timely submit the waiver renewal application.*

**Step 5.** Renewal Waiver only - Calculate the Total Previous Waiver Period Expenditures (Casemix for R1 and R2). *Note: the Total Cost per Waiver for R1 should match the Schedule D submitted.* ***No portion of R2 should be projected in order to timely submit the waiver renewal application.*** **Instead, the State should use data from the Schedule D and complete the number of months of data used in Appendix D7.**

**Step 6.** Calculate the Total Projected Waiver Expenditures for P1 and P2.

**Step 7. Modifying the spreadsheets - In the past, a portion of R2 could be projected in order to timely submit the waiver renewal application. This is no longer necessary.**
The blank spreadsheets are automatically set to take data entered by the State for up to four MEGs). *Note: The State will never need to "estimate" actual waiver cost with this methodology. Instead, the State will use whatever actual data exists and modify the spreadsheets to reflect the length of time represented by the data.* ***This represents a change from the initial training and States should pay particular attention to this detail.***

On Appendix D7, the State will need to enter the number of months of data in each BY (for an initial and conversion waiver) and R1 and R2 (for a renewal waiver). The State will also need to enter the number of months it is projecting in P1 and P2 (typically 12 months in both P1 and P2). If there is a gap of time between the BY/R2 and P1 and P2, the State will also need to enter the number of months in the "gap".

**Example 1: Renewal with less than 2 years of data in R2**
R1 - State Fiscal Year 2001 (July 1, 2000 to June 30, 2001)
R2 - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2003 (July 1, 2002 to June 30, 2003)
P2 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)

The State wants to submit its renewal on May 1, 2002, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2002. The State then has less than two full years of R1 & R2, in this instance 12 months of R1 but only 9 months of R2:

1. The State enters the number of months for R1, R2, P1, and P2 in the spreadsheet in Appendix D7.

| **NUMBER OF MONTHS OF DATA** | | |
|---|---|---|
| | R1 | 12 |
| | R2 | 9 |
| | Gap (end of | |

| | | |
|---|---|---|
| | R2 to P1) | 3 |
| | P1 | 12 |
| | P2 | 12 |
| | TOTAL | 48 |
| | (Months-12) | 36 |

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

| Overall R1 to P2 Change (monthly) | Overall R1 to P2 Change (annualized) |
|---|---|
| **0.4%** | **5.5%** |
| **0.5%** | **5.6%** |
| **0.5%** | **5.6%** |
| **0.5%** | **6.5%** |
| **0.5%** | **6.1%** |
| **0.6%** | **7.4%** |

**Example 2: Conversion with a lag between BY and P1**
BY - State Fiscal Year 2002 (July 1, 2001 to June 30, 2002)
P1 - State Fiscal Year 2004 (July 1, 2003 to June 30, 2004)
P2 - State Fiscal Year 2005 (July 1, 2004 to June 30, 2005)

The State wants to submit its renewal on May 1, 2003, so it uses data from its CMS-64 Schedule D Quarter Ending March 30, 2003. The State then has a full year of BY but a lag between BY and P1 of 12 months:

1. The State enters the number of months for BY, gap, P1, and P2 in the spreadsheet in Appendix D7.

| NUMBER OF MONTHS OF DATA | |
|---|---|
| BY | 12 |
| Gap (end of BY to P1) | 12 |
| P1 | 12 |
| P2 | 12 |
| TOTAL | 48 |
| (Months-12) | 36 |

2. The spreadsheet will automatically calculate the monthly and annualized rate of change from R1 to P2

| Overall BY to P2 Change (monthly) | Overall BY to P2 Change (annualized) |
|---|---|
| 0.7% | 8.8% |
| 0.6% | 6.9% |
| 0.7% | 8.6% |
| 0.8% | 10.1% |
| 0.8% | 9.4% |
| 0.9% | 11.5% |

**Step 7.** Calculate the annual percentage change. For Initial and Conversion waivers, calculate the percentage change from BY to P1, P1 to P2 and BY to P2 for each MEG. For renewals, calculate the percentage change from R1 to R2, R2 to P1, P1 to P2, and R1 to P2 for each MEG. Calculate the annual percentage change for the weighted average PMPM at the Casemix for that year and at the Casemix for the previous year. In other words, calculate the annual percentage change in the PMPM compared to the previous year for that year's demographics and for the previous year's demographics. This allows CMS to compare the percentage of the PMPM that changed due to the caseload's demographics changes. The sample spreadsheets have appropriate formulas for State use. Explain these percentage changes in the State Completion section.

**Step 8.** Renewal Waiver only - list the PMPM cost projections (P1 and P2) by MEG from the previous waiver submittal.

**Step 9.** Renewal Waiver only - Calculate the Actual Previous Waiver Period Expenditures, Total Projection of Previous Waiver Period Expenditures, and Total Difference between Projections and Actual Waiver Cost for the Previous Waiver using actual R1 and R2 member months. Using actual R1 and R2 member months will hold the State harmless for caseload changes. Multiply the PMPM projections by the actual R1 and R2 member months to obtain the overall expenditures for the past Waiver Period. Subtract waiver actual waiver costs for R1 and R2 from the projected PMPM program costs previously submitted (P1 and P2 in the previous waiver submission) to obtain the difference between the Projections and Actual Waiver Cost for the retrospective period. If **Actual Waiver Service Cost plus the Actual Waiver Administration Cost is less than or equal to Projected Waiver Cost,** then the State has met the Cost-effectiveness test and the waiver may be renewed.